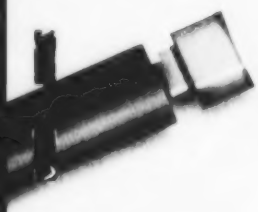
HELPING PRECONTEMPLATIVE & CONTEMPLATIVE CLIENTS:

AN EVALUATION OF THE AFM'S COMING-TO-TERMS PROGRAM



FOUNDATION OF MANITOBA

Leading the Way to an Addiction Free Society

HELPING PRECONTEMPLATIVE & CONTEMPLATIVE CLIENTS:

AN EVALUATION OF THE AFM'S COMING-TO-TERMS PROGRAM

DECEMBER, 1999

Gerry S. Kaplan

The Awareness & Information Unit Of
The Addictions Foundation Of Manitoba

~ACKNOWLEDGEMENTS~

The author acknowledges, with gratitude, the time, effort and interest of the following AFM staff:

Karin Archibald
Paul Barton
Barry Henrikson
&
Heather Mitchell

These individuals were each involved in the development of the evaluation methodology, the completion of all client-based forms, & a focus group process in which they explored the perceived benefits of the program, areas in need of review, and suggestions to colleagues in other jurisdictions considering the establishment of a program similar to Coming-To-Terms.

The author also acknowledges the time and effort provided by clients of the Coming-To-Terms Program. Without their participation in this process, which largely related to the completion of a series of related forms and questionnaires, this evaluation would not have been possible.

CONTENTS

I) BACKGROUND & METHODOLOGY

1) **Background**
- Purpose Of This Report 1

2) **Clients' Assessed Stages Of Change**
- Stages Of Change By Program 2

3) **Describing The Program**
- Program Goal & Objectives 3
- Program Sessions 4

4) **Evaluation Methodology** 6

5) **Measures Of Success For The Coming-To-Terms Program** . 7

6) **The Perceived Impact Of Precontemplative & Contemplative Clients On Other Treatment Clients**
- Precontemplative & Contemplative Client Characteristics 8
- Their Impact Upon The Group Process 9
- Effects Of Having Groups With Precontemplative & Contemplative Clients 9
- Predicted Benefits Of Referring Precontemplative & Contemplative Clients To A Separate Program 10

II) A BRIEF RESPONDENT PROFILE

1) **Respondent Characteristics**
- By Gender 11
- By Age 12
- By Education 12
- By Referral Source 12
- Physical Symptoms Reported By Clients 14
- Clients' Previous Involvement With Chemical Treatment 17

III) CLIENTS FULFILLING THEIR COMMITMENTS

1) **Background** 21

2) **Clients Fulfilling Their Commitments**
- Maintaining Abstinence 21
- Attending Self-Help Meetings 21
- Participating In Groups 21
- Completing Assignments 21

CONTENTS

IV) EVALUATING PROGRAM OUTCOMES & OUTPUTS

1) **Background** 27

2) **Evaluating Program Outcomes**
- Clients Identifying Their Substance Abuse Issues 27
- Clients Developing Achievable Harm Reduction Goals 27
- Clients' Stages Of Change 29
  - Rates & Directions Of Change 30

3) **Evaluating Program Outputs**
- Reasons For Closure 32
- Clients Completing The Program 33
- Referrals Made Upon Exit 33

V) EVALUATING CLIENT SATISFACTION WITH THE PROGRAM

1) **Background** 35

2) **What Clients Felt They Gained Through The Program**
- Evaluating Learning & Personal Development Experienced Through The Program 35
- Respondents' Confidence Following The Program 37

3) **Respondents Evaluating The Services They Received** ... 38

4) **Evaluating Global Measures Of Satisfaction**
- Measuring Overall Satisfaction 40
- Intentions To Use The AFM In The Future 43
- Intentions To Recommend The AFM To Others 43

VI) STAFF EVALUATING THE PROGRAM

1) **Background** 49

2) **Staff Evaluation Results**
- Objectives Achieved Regarding Clients In Other Programs . 49
- Objectives Achieved Regarding Coming-To-Terms Clients .. 51
- Staff Evaluating Global Program Success 52
- Staff Perceptions Of Program Strengths 53
- Staff Perceptions Of Program Limitations 54

3) **Advice To Others Considering Implementation Of A Similar Program** 54

CONTENTS

VII) STUDY CONCLUSIONS 59

1) **Client Demographics** 59

2) **Meeting Program Objectives** 60

3) **Meeting Program Expectations** 60

4) **Other Performance Measures** 60
- Client Completion Rates 60
- Stages Of Change 61
- Impact Upon Clients In Other Programs 62
- Client Satisfaction With The Program 62
- Staff Evaluations Of The Program 63

~APPENDICES~

STUDY QUESTIONNAIRES & FORMS

A BRIEF REVIEW OF THE SEVEN STAGES OF CHANGE

SELECTED FREQUENCY TABLES FOR THE CLIENT SATISFACTION EVALUATION

CHAPTER ONE
BACKGROUND AND METHODOLOGY

I) BACKGROUND:

Clients entering addictions programs seek assessment for a variety of reasons. Some clients may experience consequences if they do not attend treatment, including loss of employment, a marital separation or divorce, loss of parental rights, eviction from their residence, and so on. It is speculated that there are few totally voluntary clients, where this would imply no external forces at play. As a result, individuals approaching treatment possess a range of motivation.

At **The Addictions Foundation of Manitoba**, client assessment is based in part on ***the Stages Of Change Model***. Within an addictions treatment context, the model allows staff to determine clients' motivation to successfully resolve their alcohol or other drug usage and related issues.

There are seven levels to the Stages Of Change model,[1] including:

- **Precontemplative**
- **Contemplative**
- **Preparation**
- **Action**
- **Maintenance**
- **Recycle**
- **Termination**

Until recently, clients attending AFM Community-Based Adult Programs, in Winnipeg Region, were assigned to treatment groups without considering their respective stages of change. This meant that clients who had accepted their alcohol and drug problems, and were prepared to take action on these, could be in a group with clients who not only did not necessarily want to be there, but may not even recognize they have a problem requiring treatment or a group intervention process. As a result, staff were concerned that the ***Precontemplative and Contemplative clients*** may be having a deleterious effect on the treatment outcomes experienced by other clients.

In September, 1997, staff of AFM's Community Based Treatment Program initiated a pilot project that would stream Precontemplative and Contemplative clients into a separate program: the ***Coming-To-Terms Program***.

1.1) The Purpose And Focus Of This Report:

This evaluation is ***formative*** in nature. The resulting report highlights evaluation results of the **Coming-To-Terms Program**, in order to inform both AFM managers and staff, and external agencies considering establishing similar services for their clients who are in the Precontemplative and Contemplative stages of change. The evaluation itself subsumes the following components: program outputs, client satisfaction and outcomes, and AFM staff perceptions regarding program efficacy.

II) CLIENTS' ASSESSED STAGES OF CHANGE:

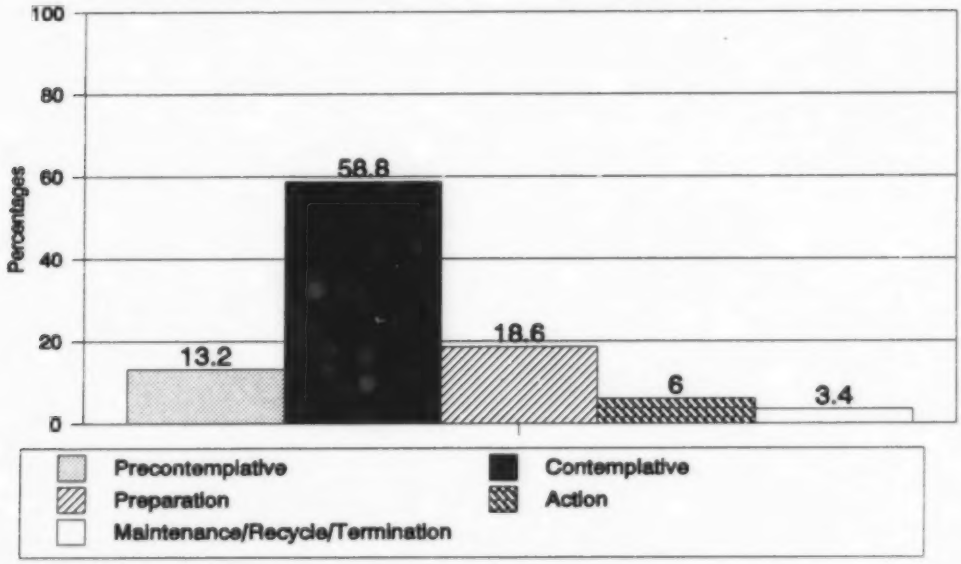
Since 1998/99, counsellors in Adult Treatment programs assessed clients' stages of

---

[1] A brief description of each of the ***stages of change*** is included as an appendix to this report.

change as part of the overall assessment process. The majority of all Adult Treatment clients (58.8%) entered treatment in the **Contemplative** stage (Figure 1). Another 18.6% of these clients were assessed as being in the **Preparation** stage, and 13.2% in the **Precontemplation** stage. Only 6.0% entered treatment in the **Action** stage, while 3.4% were assessed as being either in the **Maintenance** or **Recycling** stages.

Figure 1 Winnipeg AFM Adult Rehabilitation Clients By Stages Of Change: Aggregate



(N=650)

2.1) Stages Of Change By Program:

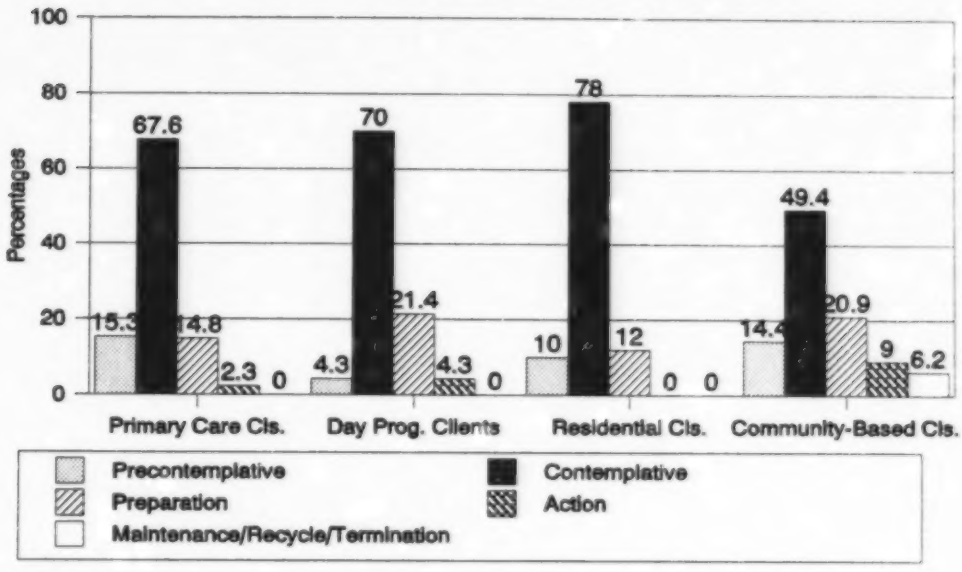
A Comparison was undertaken regarding clients' stages of change, upon entry, based on which program they entered from April, 1998 through January, 1999.[2] This included AFM' Primary Care Unit (medical stepdown); the Day Treatment Program; Residential Treatment; and the Community-Based Program. There were important differences in assessed stages of change by program (Figure 2).

Eighty-eight percent of the clients entering Residential Treatment were assessed as being Precontemplative or Contemplative, as were 82.9% of those entering the Primary Care Unit, and 74.3% of the clients entering the Day Treatment Program. In comparison, 63.8% of the clients entering the Community-Based Program were either at the Precontemplative or Contemplative stages upon entry.

Relatively few clients entered treatment in the Preparation stage, ranging from 12.0%

[2] These data were captured by the AFM's client-based information system.

Figure 2 Winnipeg Region Adult Rehabilitation Clients By Stages Of Change & Program



(N=176; 70; 50; 354)

of those entering Residential Treatment, to 21.4% of those entering the Day Treatment Program, and 20.9% of those entering Community-Based Treatment. Even fewer clients entered treatment who were in the Action stage: only 9.0% of the clients entering Community-Based Treatment, 4.3% of those entering the Day Treatment program, and 2.3% of the clients in Primary Care. None of the clients entering Residential Treatment, during this period, were assessed as being in the Action stage. Of the remaining clients entering Community-Based Treatment, 6.2% were assessed as being in either Maintenance, Recycle or Termination stages of change.[3]

III) DESCRIBING THE PROGRAM:

The Coming-To-Terms Program is comprised of four group, and two individual sessions. Group sessions are provided on consecutive weeks, over a four week period. This program is not considered therapeutic, in the traditional sense. Instead, its focus is educational. It is designed to provide information that will assist clients to realistically assess their own chemical usage, and the effect this is having on their lives, and on the lives of those around them.

This pilot program is an initiative of Winnipeg Region's Community-Based Programs. As a result, only clients who were being considered for admission to these programs were eligible to attend the Coming-To-Terms Program during this pilot phase.

[3] While it is acknowledged that these three stages of change are quite different from one another, they are grouped into a single category due to the small number of cases in each stage.

3.1) Program Goal and Objectives:

The goal of the Coming-To-Terms Program is:

> **To provide an ongoing chemical usage self-assessment opportunity for program participants.**

There are four objectives associated with this goal:

- **Participants will complete their personal life area map reflecting consequences of their chemical usage.**
- **Participants will identify their stage of change in relation to their self-assessment of chemical usage.**
- **Participants will develop written harm reduction goals.**
- **Participants will develop a written time-framed action plan to achieve their identified goals.**

3.2) Program Sessions:

Each of the four program sessions is described briefly below.

Session One:

This is the introductory session, in which program goals and objectives are stated. Participants then reveal their personal goals for the program. Variations between program and participant goals are discussed.

The specific activities in Session One include:

- Presentation and discussion regarding **the Continuum of Use Model**;
- Facilitators completing an example of a **Life Area Map**;
- Participants developing their own Life Area Maps; and
- A summary of the days activities.

Session Two:

Session two focuses on the following three activities:

- A presentation of **the Stages Of Change Model** and related behaviours.
- Each participant identifies his or her own stage of change, related to their chemical usage. This is accomplished through a group session.
- Finally, each participant determines what would be required if a person were to decide to move to the next stage of change, followed by whether or not participants are personally prepared to move at this time.

Session Three:

The activities covered in Session Three include:

- A group discussion on **the pros and cons of chemical usage and abstinence**. Each participant is expected to complete their own 'Pros and Cons' form.
- The identification of **Harm Reduction Goals**. This process is undertaken again through a group discussion, and relates to potential harm reduction goals that individuals, who are experiencing problems with chemical usage, may consider.
- Participants review harm reduction goals they had set for themselves in the past, and reflect on the degree to which they have achieved those goals. This is followed by participants setting current harm reduction goals for themselves.
- Participants then review their **self-assessment of their chemical usage**, and determine their **current stage of change**.

Session Four:

The activities in this final session include:

- Introducing the concept of the **Written Personal Plan**.
- Keeping the personal plan in mind, participants identify their personal barriers to goal attainment, the resources that are available to them toward this end, and the points that will help to ensure their goals are achieved.
- Participants are assisted in the development of their personal plan, answering the question: *where do I go from here*.
- Finally, **individual appointments** are set-up for participants to review what they feel they gained through the program, and their personal goals related to their alcohol and/or drug consumption.

3.3) Expectations Placed Upon Clients:

There are five specific expectations of clients in the Coming-To-Terms Program.

1) They are expected to maintain their abstinence throughout the program.
2) They are expected to attend at least one self-help meeting during the program.
3) They are expected to attend all program sessions, as scheduled.
4) They are expected to participate in group discussions.
5) They are expected to complete all assignments arising from the program.

IV) EVALUATION METHODOLOGY:

4.1) Staff Evaluating The Program:

i) Focus Group Process:

The first step in the evaluation process was a meeting with treatment staff, which took place prior to the implementation of this program.[4] The meeting was structured, in part, around the following questions:

- What are the characteristics of Precontemplative and Contemplative clients? How do they differ from other clients?
- How do these clients currently impact on the group process and on the effectiveness of other clients' treatment?
- What differences to the current groups are predicted after Coming-To-Terms is implemented?
- What are the measures of success for the new program?

ii) The Staff Evaluation Questionnaire:[5]

Some of the information collected through this group process, described above, was replicated as part of **the Coming-To-Terms Staff Evaluation** questionnaire. This retrospective form asked program staff the extent to which they felt that program objectives had been achieved during the pilot phase. It then asked them to evaluate how successful they felt the program had been, overall. Finally, given the formative nature of this evaluation, staff were asked the following three questions:

- What advice would staff give a colleague considering establishing a program similar to Coming-To-Terms?
- What did staff feel were the strengths of the program?
- What did staff feel were the program's limitations?

iii) Client Exit Forms:

Information captured through the client-specific **Exit Form**, which is completed by the counsellor at the point when each client leaves the program, included:

- A comparison of each client's stage of change at the point when they entered and exited the program;

  The counsellor's assessment of each client regarding:

  - whether or not they maintained abstinence throughout the program;

---

[4] This meeting took place on September 12, 1997. It involved treatment staff and the supervisor of Community-Based Programs in the AFM's Winnipeg Region

[5] Copies of all forms and questionnaires are included as an appendix to this report.

- the extent to which they participated in group discussions and completed their assignments;
- whether or not they attended at least one self-help meeting during the term of the program;
- whether they have been successful in developing achievable harm reduction goals; and
- whether the counsellor believed each client was able to identify their substance abuse issues.

- Whether each client was referred to a program following the Coming-To-Terms program, and if so, the program or agency to which the client was referred.

4.2) Clients Evaluating The Program:

Clients were asked to complete a **Client Satisfaction Questionnaire** when they left the program. This questionnaire was not necessarily limited to those who completed the program, although almost all respondents to this form were program completers. The information provided by these respondents included:

- A brief client profile, including gender, age, education, and referral source;
- Clients' previous chemical treatment history, including rates of completion of previous treatment programs;
- What clients felt they gained through the Coming-To-Terms Program;
- Clients' self-assessment of their *current* stages of change;
- The degree to which clients felt confident their chemical problems are *currently* under control;
- An evaluation of counsellors' attributes; and
- Clients' overall satisfaction with the program.

4.3) Administrative Data:

In addition to the survey-based data, this evaluation made use of administrative information collected on all clients who enter the AFM, including reasons for file closure.

4.4) Data Capture And Processing:

Completed forms were returned directly to the AFM's **Research and Evaluation Unit**, where they were scanned and processed using ***Teleform*** and ***the Statistical Package For The Social Sciences*** (SPSS).

V) MEASURES OF SUCCESS FOR THE COMING-TO-TERMS PROGRAM:

Measures of success were developed both for clients who would be attending the Coming-To-Terms Program, and for those who would remain in the current groups (i.e.

those who were assessed as being more action-oriented). The following performance measures were defined for the Coming-To-Terms Program:

5.1) General Performance Measures:

- Between 50 to 80 referrals to the program, from treatment staff, in its first year;
- The majority of clients would complete the tasks assigned during the program;
- Clients would attend all group sessions;
- Clients would demonstrate positive movement on the Stages Of Change Scale.

5.2) Performance Measures For Clients Attending Other Groups:

The measures applied to clients who remained in the standard groups, once Precontemplative and Contemplative clients had been referred to the Coming-To-Terms program, include:

- Standard groups would be more workable, more therapeutic, less negative;
- Clients in these groups would be more likely to complete treatment;
- There would be an increase in group cohesion;
- There would be greater participation from group members;
- There would be fewer disruptions in the group process;
- Staff would be less likely to report frustration, and would experience greater satisfaction.

VI) THE PERCEIVED IMPACT OF PRECONTEMPLATIVE & CONTEMPLATIVE CLIENTS ON OTHER TREATMENT CLIENTS:

Staff felt that having Precontemplative and Contemplative clients in groups with clients who were in the Preparation or Action stages was deleterious to these other clients.

6.1) Client Characteristics:

During the focus group, staff were asked to characterize Precontemplative and Contemplative clients. While the resulting traits and depictions are clearly subjective, they illustrate the impact that staff see these clients having on group processes.[6]

Precontemplative clients, as a group, were variously described as:

-Resistant	-Cocky	-Angry
-In denial	-Lacking insight	-Passive-Aggressive
-Evasive	-Aggressive	-Sarcastic

[6] It is understood that not all Precontemplative or Contemplative clients would fit the negative descriptors provided by staff, and that there are clients who would fall within one of these two stages of change categories, who would have overall positive characteristics.

-Blaming
-Belligerent
-Compliant (depending on referral source)

Contemplative clients, on the other hand, were generally characterized as being:

-Ambivalent ('Yeah, but...')
-Avoiding
-Lacking commitment
-Hard to pin down
-Intellectually aware
-Afraid of change
-Unwilling to put energy into recovery
-Challenging rules
-More focused on harm reduction than abstinence

6.2) The Impact Of Precontemplative And Contemplative Clients Upon The Group Process:

Not all Precontemplative and Contemplative clients possess the negative characteristics cited above. However, for those who do, and given the fact that many of these clients may not want to participate in programs to begin with, staff were able to relate a number of ways these clients can disrupt the group process. Some examples of disruptive behaviour, which have been experienced by staff, included:

- Clients who rationalized or intellectualized their way through a group discussion;
- Clients who attempted to discredit the counsellor;
- Clients who attempted to divert attention away from themselves when they felt threatened;
- Clients who refused to connect with the rest of the group, becoming increasingly isolated or withdrawn;
- Clients dominating a group, challenging other group members in unhealthy ways, and sometimes being disruptive in the process.

6.3) Effects Of Having Groups With Precontemplative Or Contemplative Clients:

According to staff participating in the focus group, other clients sometimes react against Precontemplative and Contemplative clients. Situations were described in which other clients were characterized as even "hating" these individuals. While some clients were characterized as being "sympathetic" toward these individuals, at times this eventually changed to feelings of "disgust" or "weariness."

From the counsellors' perspective, Precontemplative and Contemplative clients in a group can be "very frustrating." While these clients present the potential for creating "healthy exchanges" between group members, they are generally more often perceived as "disruptive," to the point where sessions are sometimes left incomplete. The bottom line in these instances is that other clients are often "relieved" when Precontemplative and Contemplative clients drop out of the program.

6.4) Predicted Benefits Of Referring Precontemplative And Contemplative Clients To A Separate Program:

Staff were asked to predict some of the benefits they believed they would experience through the advent of the Coming-To-Terms program, as these related to clients in the Preparation and Action stages. Some staff felt that with Precontemplative and Contemplative clients removed from the groups, there would be "fewer disruptions" for the remaining clients, with the corollary that "less time would be wasted." It was believed that the tenor of the remaining groups would improve as a result of this change. For example, some staff predicted that groups would be "more cohesive," and that there would be less "disruption," "antagonism" and "intimidation" among the remaining group members.

CHAPTER TWO
A RESPONDENT PROFILE

I) BACKGROUND:

This chapter provides a brief profile of study respondents by gender, age, education, physical symptoms resulting from clients' alcohol and/or other drug consumption, referral sources and previous treatment history. Comparisons are also made between clients of the Coming-To-Terms Program and those who attended other AFM Adult Treatment Programs in 1997-98 across the three AFM Regions.

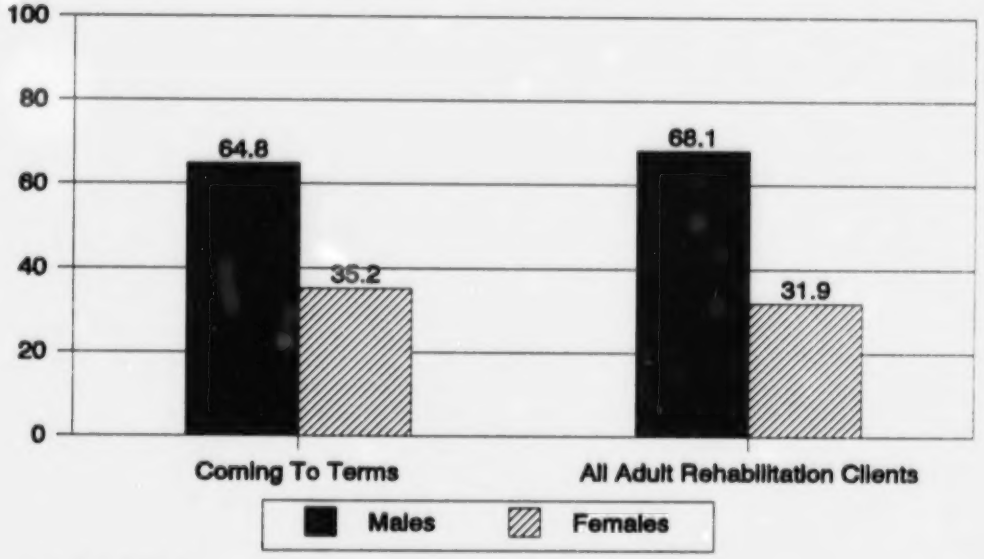
Data for this chapter were derived from the AFM's client-based information system, which tracks demographic and social indicators regarding all AFM clients.[7]

II) RESPONDENTS' CHARACTERISTICS:

2.1) By Gender:

Almost two-thirds of the respondents in this study were male, and 35.2% were female (Figure 3). This gender distribution was similar to that of clients who attended all Adult Treatment Programs in the 1997/98 fiscal year (i.e. 68.1% males and 31.9% females).

Figure 3 Client Profile By Gender & Program



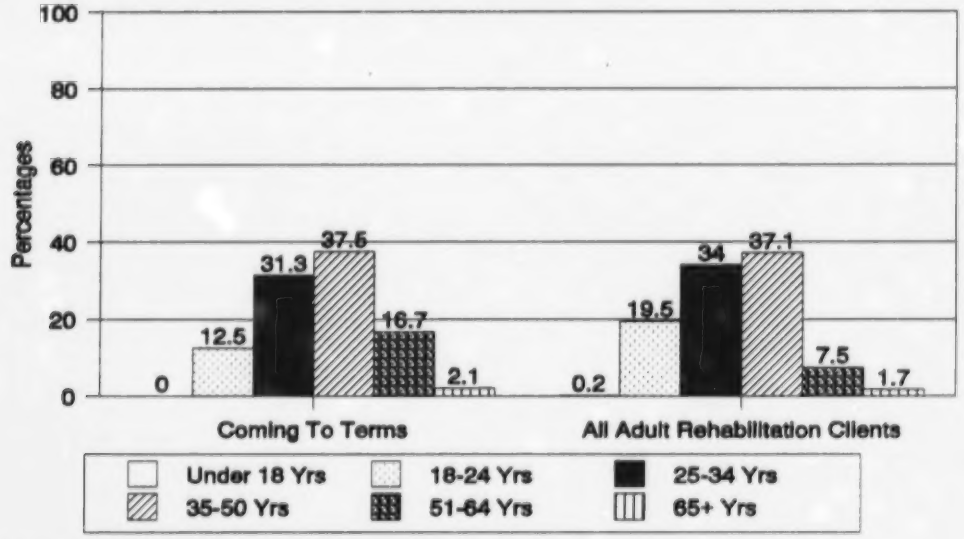
(N=54; 3477)

[7] In order to make this report easier to read, respondents who attended the Coming-To-Terms program will be referred to simply as *the respondents*, as opposed to other clients.

2.2) By Age:

The age distributions of study respondents were generally similar to that of all other Adult Treatment Clients (Figure 4). The majority of clients were 35 to 50 years of age (37.5% and 37.1% for respondents and other clients, respectively). These were followed closely by 25 to 34 year olds (31.3% and 34.0%, respectively). There was a smaller percentage of 18 to 24 year olds in the respondent group than in the larger group (12.5% compared with 19.5%). There were proportionately more clients in the respondent group over 50 years of age (18.8% compared to 9.2%, respectively).

Figure 4 Client Profile By Age & Program



(N=48; 3000)

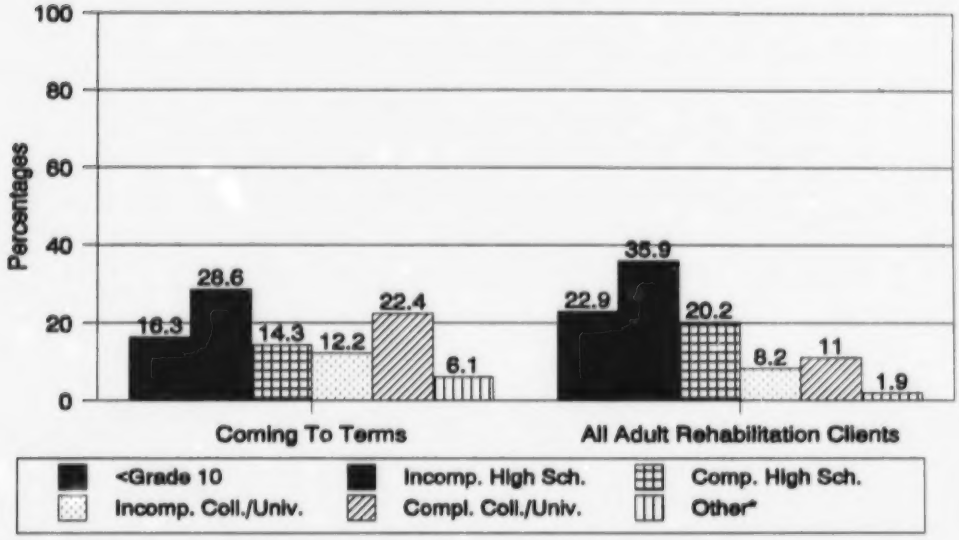
2.3) By Education:

Study respondents had attained more education than those in other Adult Treatment Programs (Figure 5). While 44.9% of those in the Coming-To-Terms Program had either less than a grade ten education or incomplete high school, this was reported by 58.8% of the clients in other programs. Other Adult Treatment clients were somewhat more likely to have completed high school than were the Coming-To-Terms clients (20.2% compared with 14.3%, respectively). Finally, 22.4% of those in the Coming-To-Terms Program reported completing secondary, or post-secondary degrees or certificates, compared with 11.0% of the other clients.

2.4) By Referral Source:

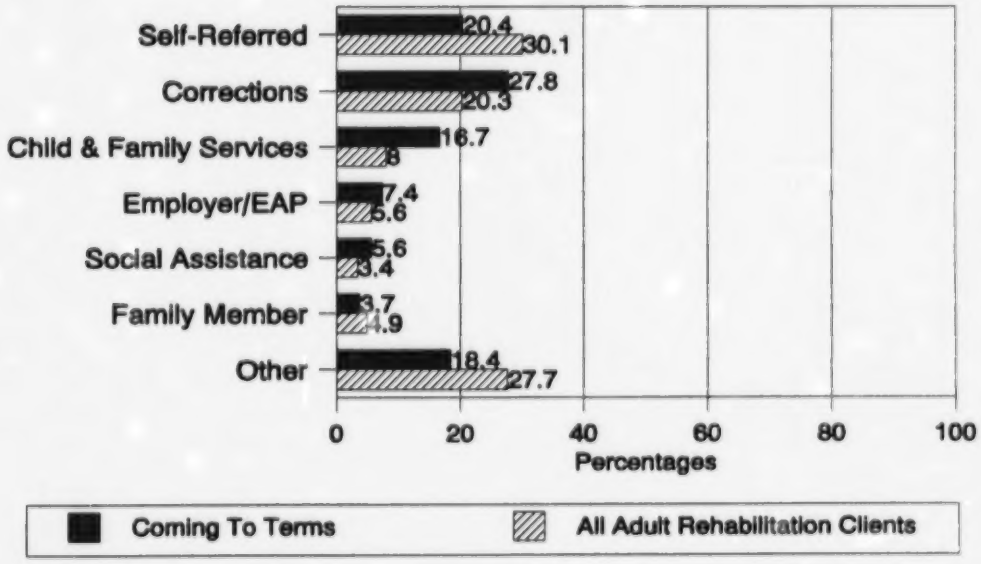
Based on information derived from client assessment forms, there were some

Figure 5 Client Profile By Education & Program



(N=49; 3572)

Figure 6 Client Profile By Referral Source & Program



(N=54; 3606)

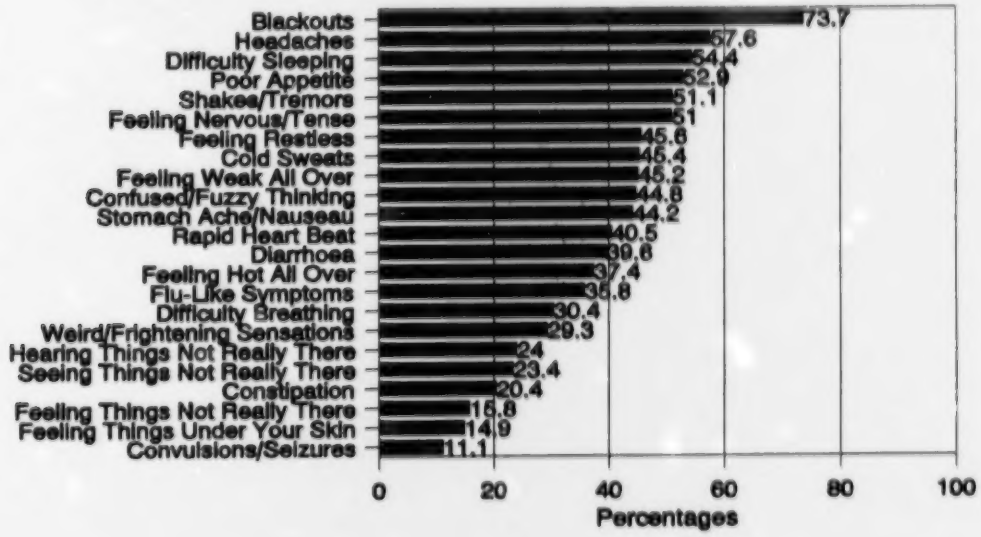
differences between these two client groups regarding reported referral sources (Figure 6). First, clients in the Coming-To-Terms Program were less likely to report being self-referred than were their counterparts (20.4% and 30.1%, respectively). Instead, they were more likely to report having been referred by corrections, probation or parole services (27.8% compared with 20.3%), and Child and Family Services (16.7% compared with 8.0%).

Clients in other programs were more likely than those in the Coming-To-Terms Program to report having been referred by some other source (27.7% compared with 18.4%). These included: community medical services, NNADAP, hospitals, schools, and the Department of Driver and Motor Vehicle Licensing (DDVL).

2.5) Physical Symptoms Reported By Clients:

As part of the assessment process, all clients are asked to describe physical symptoms they have experienced as a direct result of their alcohol and/or other drug consumption. While all clients tended to report a range of related symptoms, those in the Coming-To-Terms Program appeared slightly less likely to do so. There were several notable exceptions to this observations. In the aggregate (i.e. for all clients regardless of program), the most commonly experienced symptom, resulting from alcohol or other drug consumption, was blackouts (73.7%) (Figure 7). Another five symptoms were reported by the majority of clients, including: headaches (57.6%); difficulty sleeping (54.4%); poor appetite (52.9%); shakes and/or tremors (51.1%); and feeling nervous and/or tense (51.0%).

Figure 7 Symptoms Ever Experienced By Clients Due To Alcohol/Drug Use: All Clients



(N=3346. Multiple Responses Are Allowed)

Between forty and forty-six percent of all these clients also reported: feeling restless (45.6%); cold sweats (45.4%); feeling weak all over (45.2%); confused or fuzzy thinking (44.8%); stomach aches or nausea (44.2%); and rapid heart beat (40.5%). The remaining eleven symptoms were reportedly experienced by between 39.6% and 11.1% of the aggregate client population. Overall, clients reported an average of **8.9 symptoms** associated with alcohol and/or drug consumption.

Comparing Clients By Program:

Clients in both the Coming-To-Terms Program, and other programs were equally as a likely to report blackouts (72.9% and 73.7%) and difficulty sleeping (58.3% and 54.4%) (Table 1). Clients in the Coming-To-Terms Program were slightly more likely to report headaches, as a result of consumption, than were their counterparts (62.5% and 57.6%).

Table 1) Symptoms Reported By Clients By Program Area (Multiple Responses Are Allowed) (Ranked Responses)

	Coming-To-Terms Clients		All Other Adult Treatment Clients	
SYMPTOMS	N	%	N	%
Blackouts	35	72.9%	2431	73.7%
Headaches	30	62.5	1898	57.6
Difficulty Sleeping	28	58.3	1793	54.4
Poor Appetite	23	47.9	1747	53.0
Shakes/Tremors	14	29.2	1697	51.5
Nervous/Tense	16	33.3	1692	51.3
Restless	16	33.3	1509	45.8
Cold Sweats	15	31.3	1503	45.6
Feeling Weak All Over	16	33.3	1495	45.3
Confused/Fuzzy Thinking	19	39.6	1481	44.9
Stomach Ache/Nausea	21	43.8	1457	44.2
Rapid Heart Beat	13	27.1	1343	40.7
Diarrhoea	16	33.3	1309	39.7
Feeling Hot All Over	13	27.1	1239	37.6
Flu-Like Symptoms	17	35.4	1181	35.8
Difficulty Breathing	7	14.6	1010	30.6
Weird/Frightening Sensations	12	25.0	968	29.4
Hearing Things Not Really There	5	10.4	798	24.2
Seeing Things Not Really There	5	10.4	778	23.6
Constipation	8	16.7	675	20.5

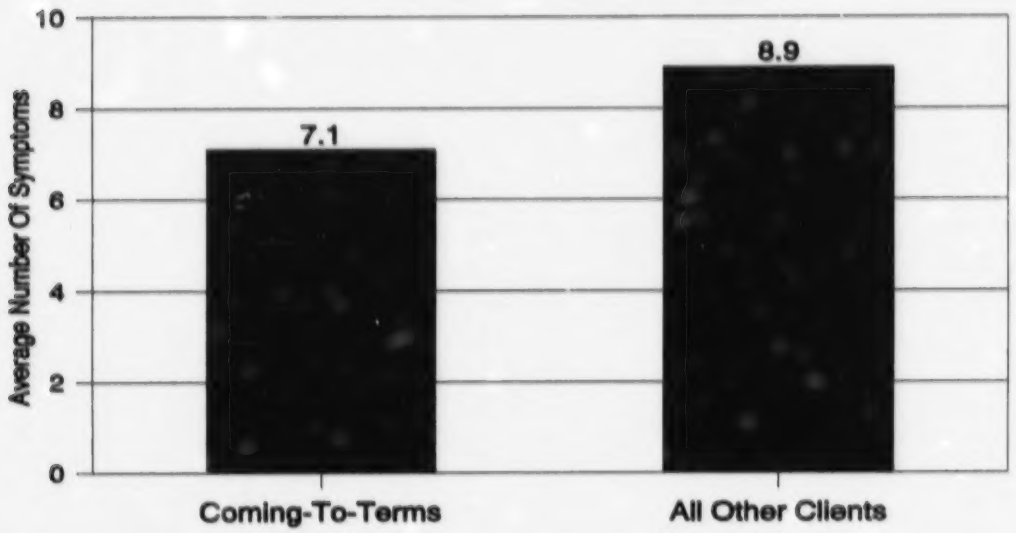
	Coming-To-Terms Clients		All Other Adult Treatment Clients	
SYMPTOMS	**N**	**%**	**N**	**%**
Feeling Things Not Really There	2	4.2	526	15.9
Feeling Things Crawl Under Your Skin	6	12.5	491	14.9
Convulsions/Seizures	5	10.4	365	11.1
TOTALS	**48**	**712.5%**	**3298**	**891.0%**

In all other instances, clients in other treatment programs were more likely than their counterparts to report a range of symptoms. Most notable among these were: shakes and tremors; feeling nervous or tense; experiencing 'cold sweats'; experiencing rapid heart beat; experiencing difficulty breathing; visual and auditory hallucinations; feeling weak all over; feeling restless; and feeling things that 'were not really there.'

Computing Variations In Symptomatology:

Differences between these groups of clients can be better summarized by calculating the average number of symptoms each one reported ever experiencing. Clients in the Coming-To-Terms Program had reported an average of **7.1 different symptoms** they attributed to their use of alcohol or other drugs (Figure 8). This is compared with an average of **8.9 symptoms** reported by all other Adult Treatment clients.

Figure 8 Average Number Of Symptoms Reported By Clients: By Program



(N=48; 3298)

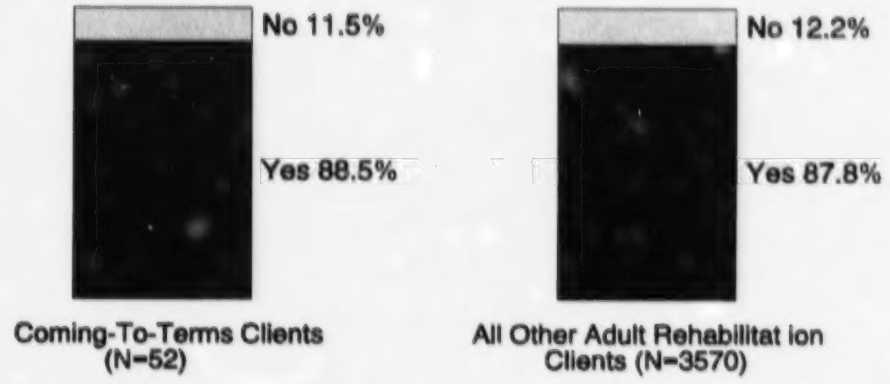
2.6) Clients' Previous Involvement With Chemical Treatment:

Several questions contained in the assessment forms detail their clients' treatment histories prior to the 'current' assessment.

i) Clients Who Have Tried To Cut Down On Their Own:

All clients are asked whether they *have ever tried to quit or cut down on their alcohol or other drug use on their own.* The large majority of clients, regardless of program, reported they had done so: 88.5% of those in the Coming-To-Terms Program, and 87.8% of the clients in other Adult Treatment Programs (Figure 9).

Figure 9 Have Clients Ever Tried To Quit Or Cut Down On Their Use: By Program



ii) Clients Previously Attending Another Alcohol Or Drug Treatment Program:

Clients from the Coming-To-Terms Program were less likely to report having previously attended a chemical treatment program (Figure 10). Just over one-quarter of these clients (28.6%) reported previous program attendance, compared with 45.0% of those in all other Adult Treatment Programs.

Given that clients in the Coming-To-Terms Program, by definition, may not recognize the nature of their chemical problems, this findings is not unexpected.

Figure 10 Have Clients Ever Attended Another Alcohol/Drug Treatment Program? By Program

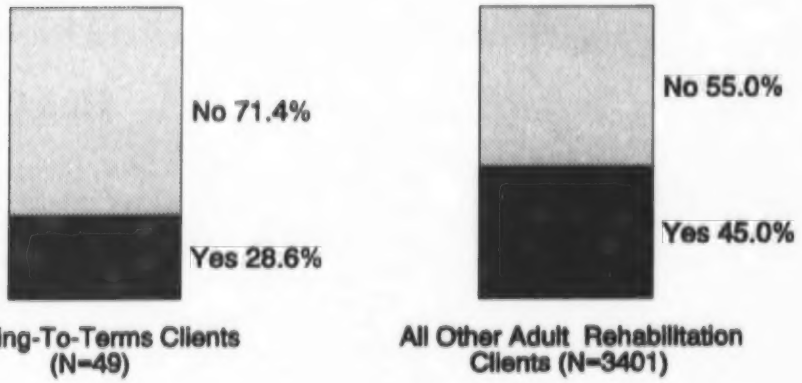
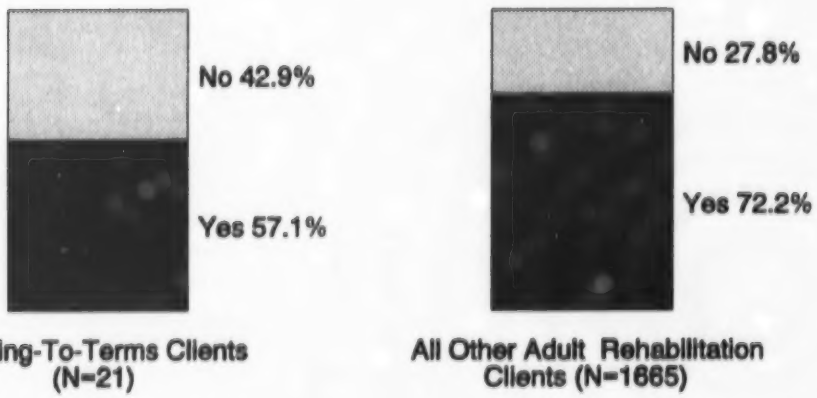


Figure 11 If They Attended Another Program, Had They Completed It? By Program



iii) Clients Completing The Last Program They Attended:

Clients who had previously attended a treatment program were asked whether or not they completed that program. From the data, clients attending the Coming-To-Terms Program, who had attended a previous program, were less likely than their counterparts to have completed that program (57.1% compared with 72.2%) (Figure 11). Once again, these differences are not surprising.[8]

[8] It should be noted that this information is self-reported. The AFM does not routinely verify whether clients, in fact, did complete the last program attended.

CHAPTER THREE
CLIENTS FULFILLING THEIR COMMITMENTS

I) BACKGROUND:

There were several expectations placed on clients in the program. These included:

- Maintaining abstinence throughout their time in the program;
- Attending at least one self-help meeting during this time;
- Attending all sessions;
- Participating in group discussions; and
- Completing their assignments.

Counsellors were asked to report on the degree to which clients followed through with their commitments. These questions were part of the exit form completed by counsellors on each of their clients in this program. From their responses, it appears that most clients did follow through in this respect. This chapter explores the extent to which this actually occurred.

II) CLIENTS FULFILLING THEIR COMMITMENTS:

2.1) Maintaining Abstinence:

Counsellors reported that almost eighty percent of all clients in this study reported (79.5%) maintaining abstinence throughout the program (Figure 12). Not unexpectedly, clients assessed as being Precontemplative at the point of exit were least likely to have maintained abstinence throughout the program (40.0%). This is compared with 75.0% of those assessed as Contemplative at exit, 90.5% of those in the Preparation stage, and 80.0% of those in the Action stage.

2.2) Attending Self-Help Meetings:

Counsellors also reported that 83.7% of all clients indicated attending at least one self-help meeting during their time in the program (Figure 13). Once again, clients who were assessed as Precontemplative at exit were least likely to have attended a meeting (40.0%). The large majority of the Contemplative, Preparation and Action clients attended at least one meeting (91.7%, 90.5% and 80.0%, respectively).

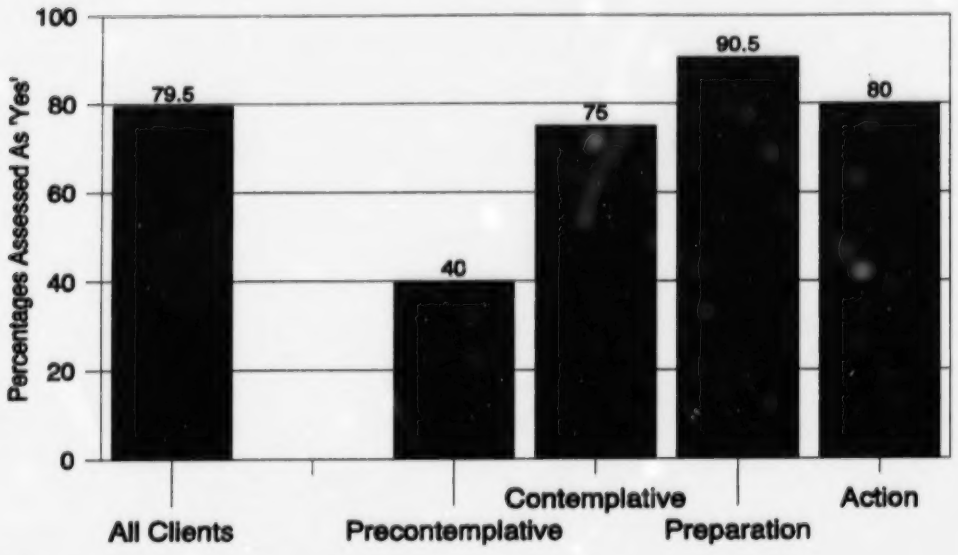
2.3) Participating In Groups:

Counsellors reported that 90.9% of these clients participated in the group at least somewhat (Figure 14). Of these, 59.1% were seen to have very much participated in group discussions. Group participation was greatest among those clients assessed as being in the Action stage (100% 'very much' participating) and least among those assessed as Precontemplative upon exit (with 60.0% participating in groups either very little or 'not at all') (Figure 15). Contemplative clients, and those assessed as being in the Preparation stage, generally, participated either 'very much' or 'somewhat.'

2.4) Completing Assignments:

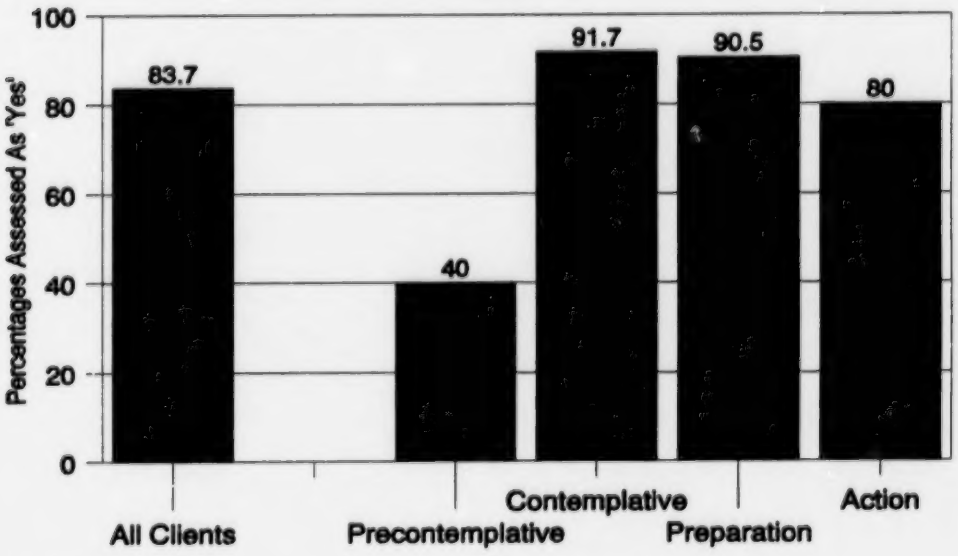
Almost all clients were reported to have completed at least some of their assignments (95.5%) (Figure 16). Half of all clients 'very much' completed their assignments.

Figure 12 Did Clients Maintain Abstinence In The Program: By Stage Of Change On Exit



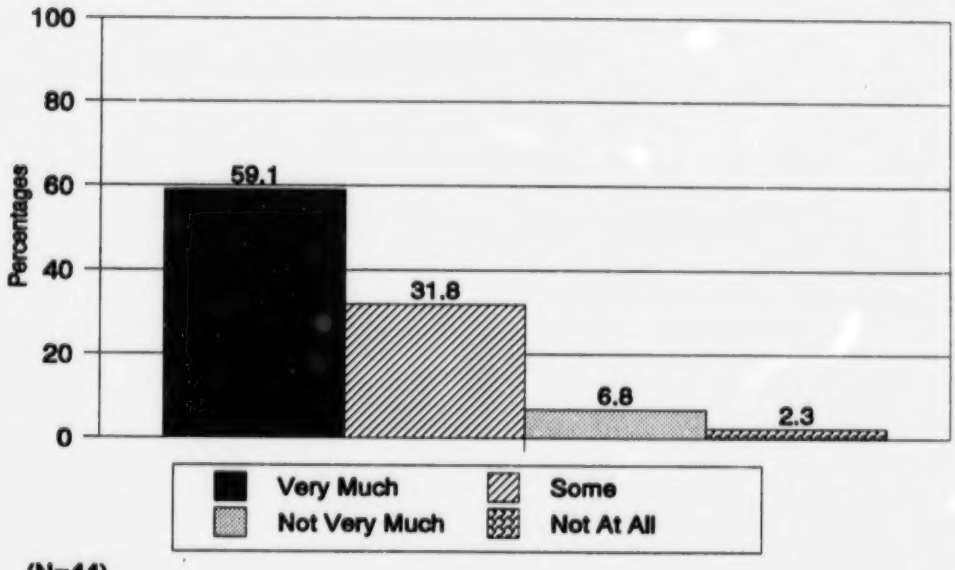
(N=44; 5; 12; 21; 5)

Figure 13 Did Clients Attend At Least One Self-Help Meeting? By Stage Of Change On Exit



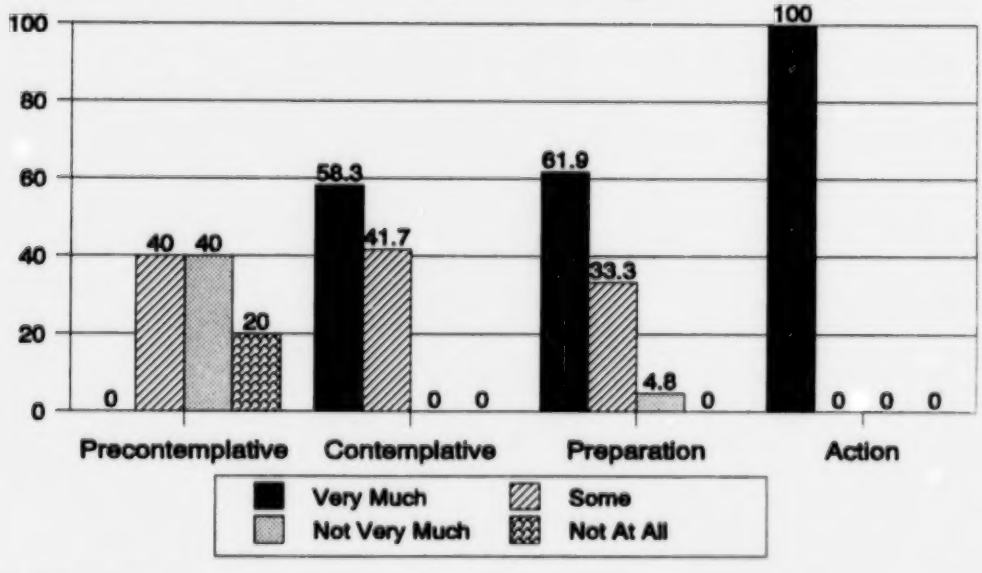
(N=44; 5; 12; 21; 5)

Figure 14 Did Clients Participate In Group Discussions?



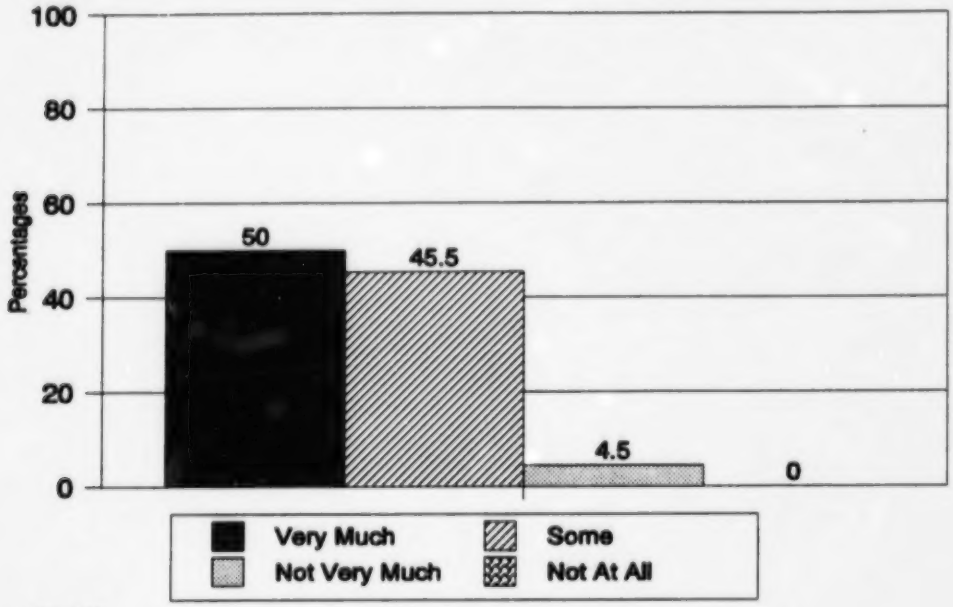
(N=44)

Figure 15 Counsellor's Assessment Of Clients' Group Participation By Exit Stage Of Change



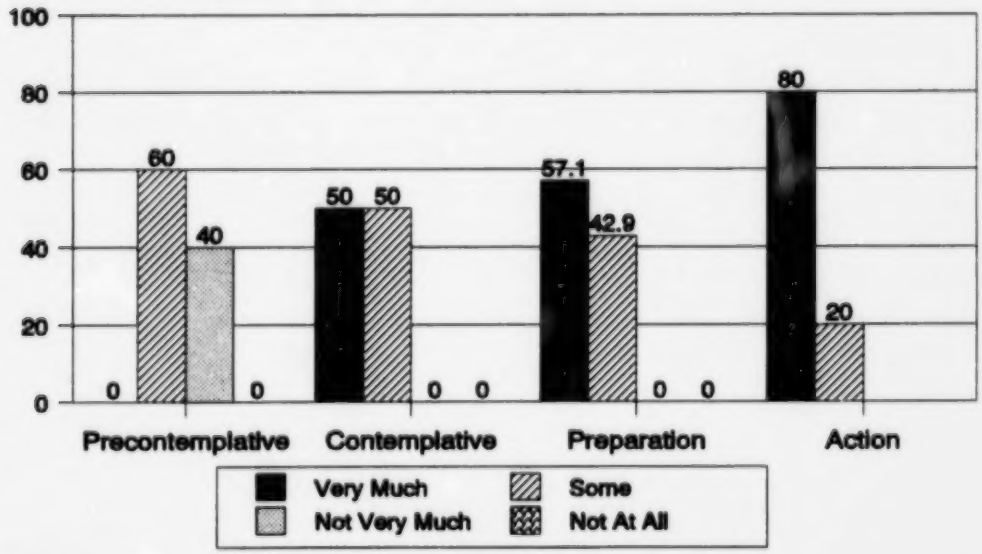
(N=5; 12; 21; 5)

Figure 16 Did Clients Complete Assignments?



(N=44)

Figure 17 Counsellor's Assessment Of Clients' Assignment Completion By Exit Stage



(N=5; 12; 21; 5)

Consistent with preceding findings, clients still assessed as Precontemplative upon exit were least likely to have completed their assignments (Figure 17). Sixty percent of these individuals (n=5) completed some assignments, while the remaining 40.0% generally did not. Conversely, 80% of the clients in the Action stage upon exit very much completed their assignments, with the remaining respondent completing some assignments. All respondents in the remaining two stages completed at least some of their assignments during the course of the program.

CHAPTER FOUR
EVALUATING IMMEDIATE PROGRAM OUTCOMES & OUTPUTS

I) BACKGROUND:

This chapter examines program outcomes and outputs. ***Program Outcomes***, for the purposes of this report, defines what occurred and was accomplished by clients during the course of the program. It does not relate to what transpired for clients subsequent to their leaving the program. Elements of this analysis include:

- Counsellors' perceptions of client progress;
- Counsellors' assessment of client stages of change over time;
- The degree to which clients completed the program; and
- Counsellors' referrals following the program.

Program Outputs, on the other hand, track:

- The reasons given by staff for clients leaving the program;
- The percentage of clients who completed the program; and
- Any referrals that resulted.

For purposes of analysis, data regarding program outputs compares Coming-To-Term clients with other Winnipeg Region Adult Treatment clients.

II) EVALUATING PROGRAM OUTCOMES:

2.1) Clients Identifying Their Substance Abuse Issues: Their Counsellors' Perceptions:

In the large majority of cases (93.2%), counsellors felt that program clients had at least somewhat identified their substance abuse issues (Figure 18). In about one-third of the cases (36.4%), counsellors reported that this very much occurred. In three cases (6.8%) there was some question regarding whether this had occurred.

2.2) Clients Developing Achievable Harm Reduction Goals:

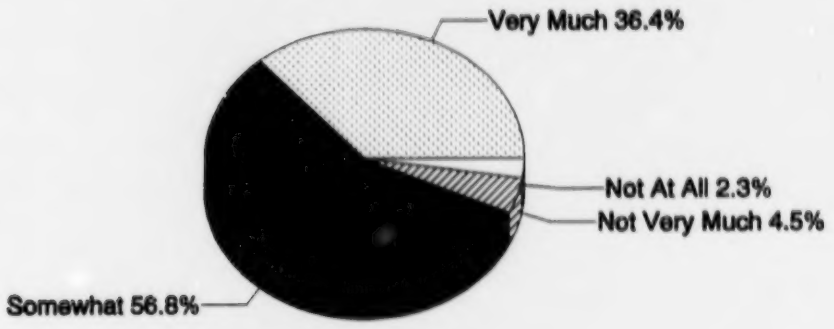
i) Counsellors' Perceptions:

Similarly, counsellors believed a large percentage of their clients had at least somewhat developed achievable harm reduction goals (Figure M). Of these, in 70.4% of the cases at least somewhat achievable goals were developed, while very achievable goals were developed by another 15.9% of these clients. Conversely, in five cases (11.4%), the counsellors felt that this did not really occur, and in one instance it did not occur at all.

ii) Clients' Perceptions:

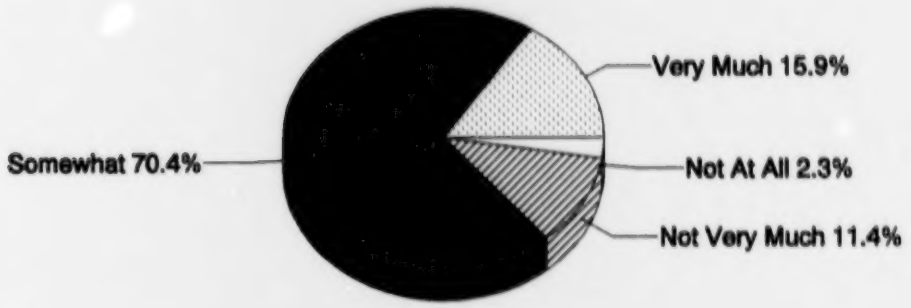
Consistent with counsellors' perceptions, 88.9% of the clients in this study reported

Figure 18 Degree To Which Counsellors Believe Clients Have Identified Substance Abuse Issues



(N=44)

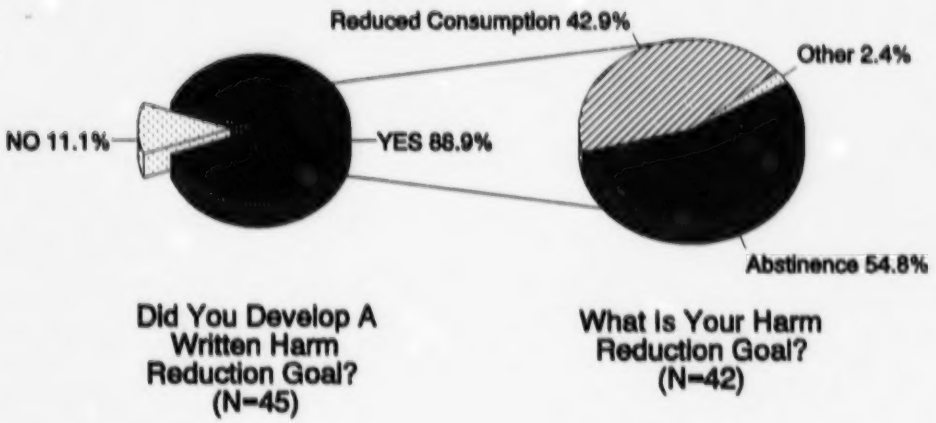
Figure 19 Degree To Which Counsellors Believe Clients Have Achievable Harm Reduction Goals



(N=44)

developing harm reduction goals (Figure 20). When asked what their specific goals were, 54.8% reported they would attempt to maintain abstinence, 42.9% reported they would attempt to reduce their consumption, and 2.4% reported some other goal.

Figure 20 Clients' Harm Reduction Goals



2.3) Clients' Stages Of Change:

Counsellors' Perceptions:

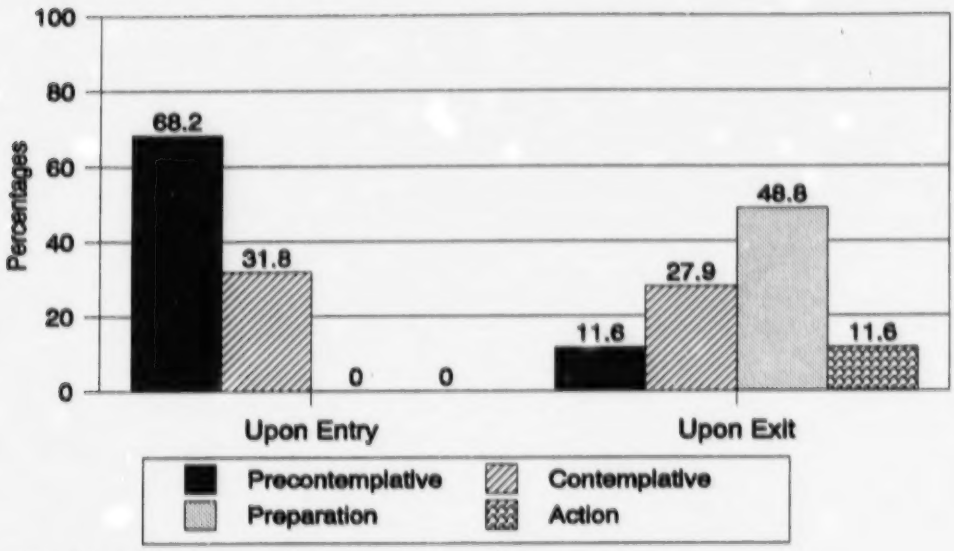
Perhaps one of the most important measures of client progress relates to their stages of change, over time. Just over two-thirds of the Coming-To-Terms clients in this evaluation (68.2%) were assessed as being Precontemplative upon entering the program (Figure 21). The remaining 31.8% of these clients were assessed as Contemplative.

Assessing these same clients upon exit from the program, and comparing these pre- and post data, some important shifts emerged. At this juncture, only five clients (11.6%) remained at the Precontemplative stage, while another 27.9% were assessed as being Contemplative. However, just under half of the respondents, upon exit (48.4%), were assessed as being in the Preparation stage, while 11.6% were viewed as being in the Action stage.

Clients' Perceptions:

The foregoing information was based on counsellors' assessments of clients' stages

Figure 21 Counsellor's Assessment Of Stages Of Change At Entry And Exit From Program



(N=44; 43)

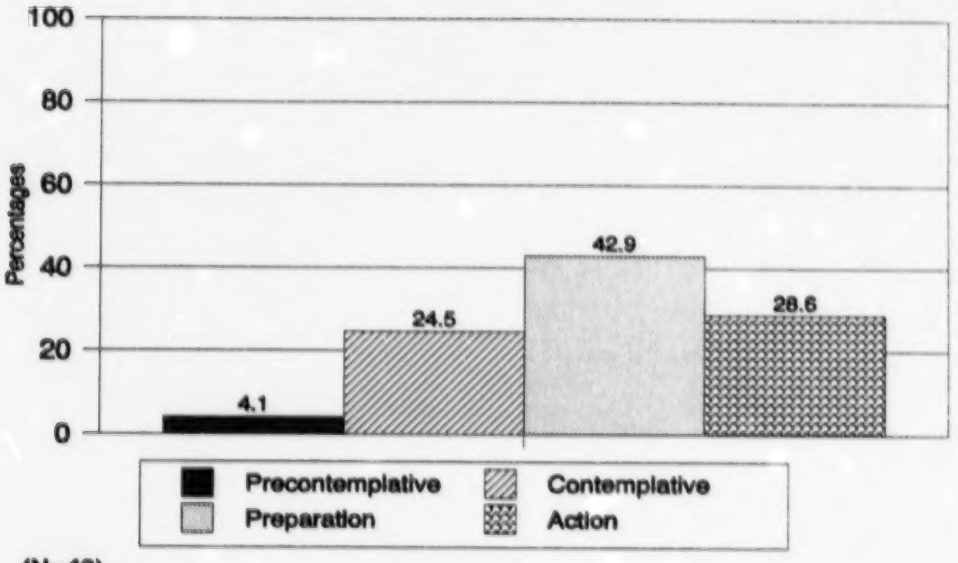
of change, over time. As part of the satisfaction evaluation form, clients were asked to rate their own stages of change upon exit. Clients' self-assessments, which were undertaken in isolation from their counsellors, closely mirrored counsellors' assessments, although some clients tended to be more optimistic in their assessments than did the counsellors they worked with (Figure 22). In this instance, one client (4.1%) reported being Precontemplative; 24.5% were in the Contemplation stage, 42.9% reported being in the Preparation stage, while 28.6% felt they were in the Action stage.

2.4) Rates & Directions Of Change:

Based on counsellors' assessments, almost all clients in this study demonstrated positive change over time, regarding their respective stages of change (Figure 23). The largest percentage of clients (30.2%) progressed two stages, from Precontemplative to Preparation. One-quarter (25.6%) progressed from Precontemplative to Contemplative. Just under twenty percent of the clients in this study (18.6%) progressed from Contemplative to Preparation, while 9.3% progressed from Contemplation to Action. In one instance, the client progressed from Precontemplation directly to Action.

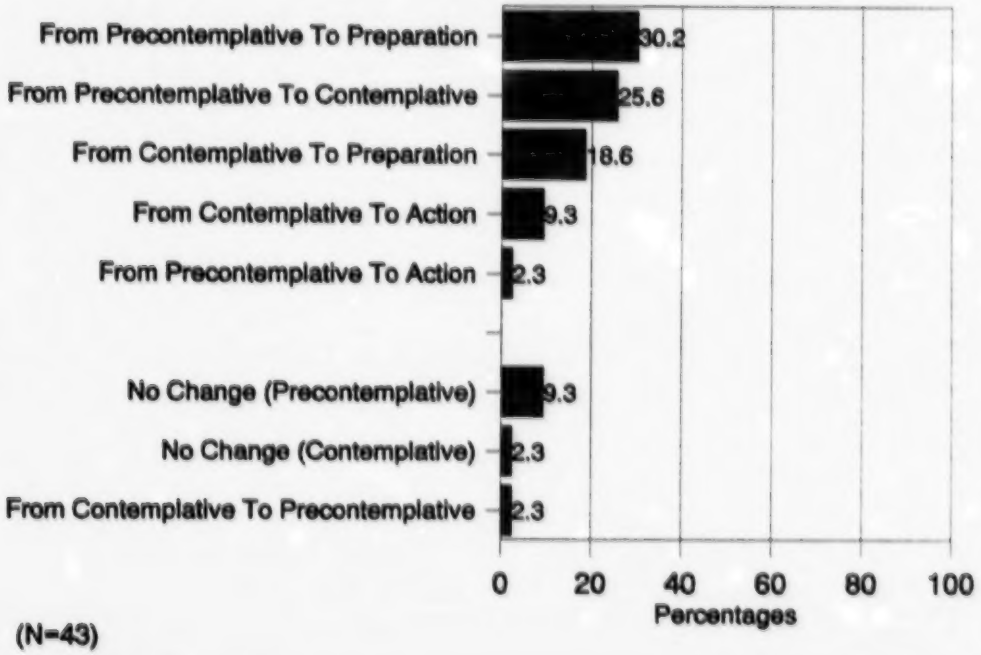
In several cases there were no changes in clients' stages of change. In four cases, clients entered the program in the Precontemplative stage and did not progress beyond this. In another instance, a client entered and exited the program in the Contemplative stage. Finally, one client digressed from being Contemplative upon entry to Precontemplative upon exit from the program.

Figure 22 How Would Clients Describe Their Stages Of Change, Upon Exit?



(N=49)

Figure 23 Clients' Rate & Direction Of Change



(N=43)

III) EVALUATING PROGRAM OUTPUTS:

There were three program outputs examined for this evaluation:

- Reasons for closure;
- Number of clients who completed programs; and
- Referrals made for clients upon exit.

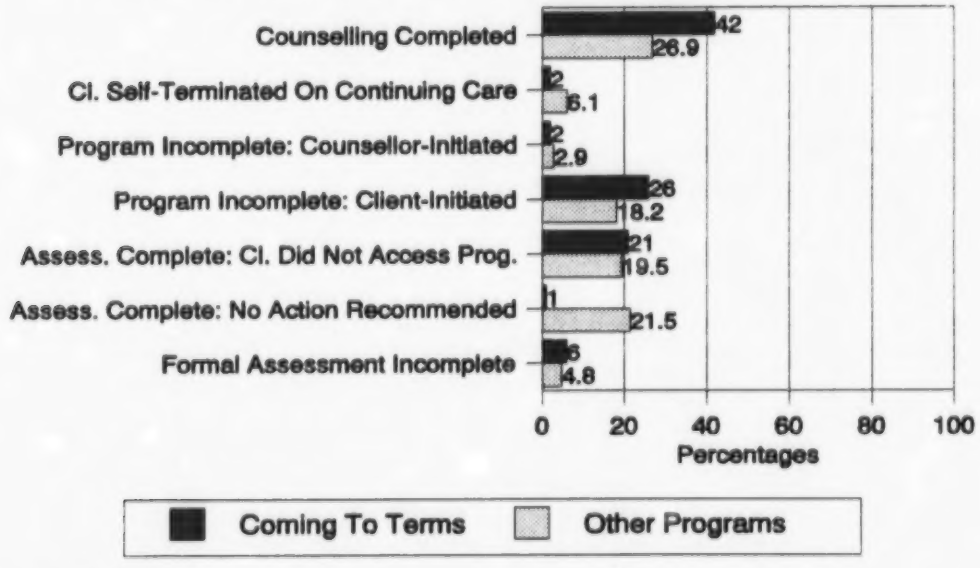
Keeping in mind the high drop-out rates of clients assessed as Precontemplative or Precontemplative, questions regarding reasons for closure, including whether or not clients completed the program, take on heightened importance.

3.1) Reasons For Closure:

As part of the process to close client files, counsellors provide the reason why the file was being closed. These can include the client and counsellor agreeing that treatment goals have been achieved, clients self-terminating on continuing care, clients leaving the program prematurely (on the initiative of either the client or counsellor), and clients not accessing or completing the program to which they were referred. Alternatively, the counsellor may determine, following assessment, that no further action is required for this client.

Comparing the related data of the Coming-To-Terms clients with other clients attending Adult Treatment Programs, the former were more likely to complete treatment (42.0% compared with 26.9%, respectively) (Figure 24). When it came to clients in other Adult

Figure 24 Reasons For Closure By Program: Adult Treatment Clients Winnipeg Region



(N=100; 687)

programs, counsellors were much more likely to close their files on the basis that no further action was required than was the case for clients in the Coming-To-Terms Program (21.5% and 1.0% of the closed files, respectively).

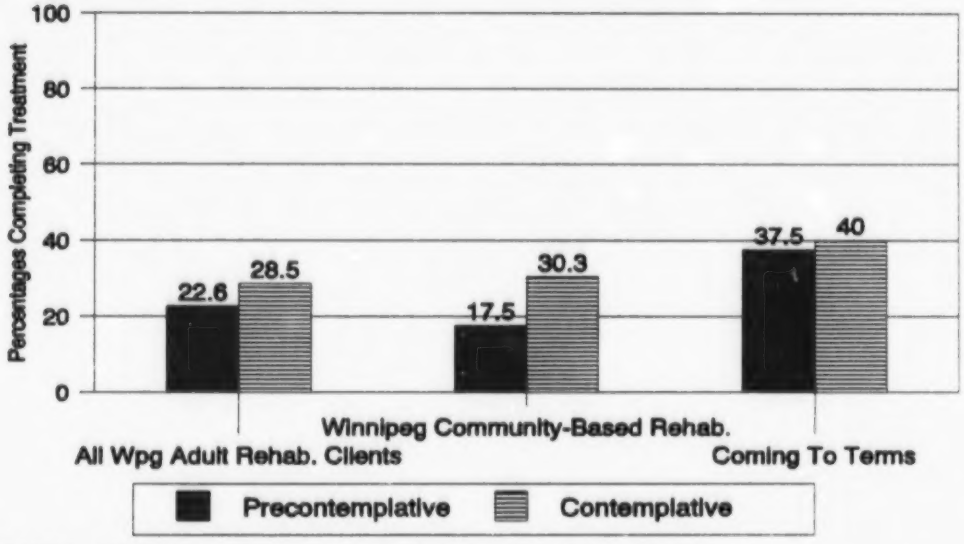
3.2) Clients Completing Treatment By Program:

Treatment completion is defined as the counsellor and client agreeing that the treatment plan has been achieved or completed. It also signifies that both the client and counsellor agree that further counselling or treatment are not required. From the data, the completion rates for Precontemplative and Contemplative clients, in the Coming-To-Terms Program, was 37.5% and 40.0%, respectively (Figure 25).

These figures compare quite favourably with completion rates for similar clients in other program. For example, in terms of all Winnipeg-Region based Adult Treatment Program clients, the completion rate for Precontemplative and Contemplative clients, during this same period was 22.6% and 28.5%.

Results were generally similar with regard Precontemplative and Contemplative clients attending Winnipeg-Region's other Community-Based Programs (17.5% and 30.3%, respectively).

Figure 25 Percentages Of Precontemplative & Contemplative Clients Completing Treatment



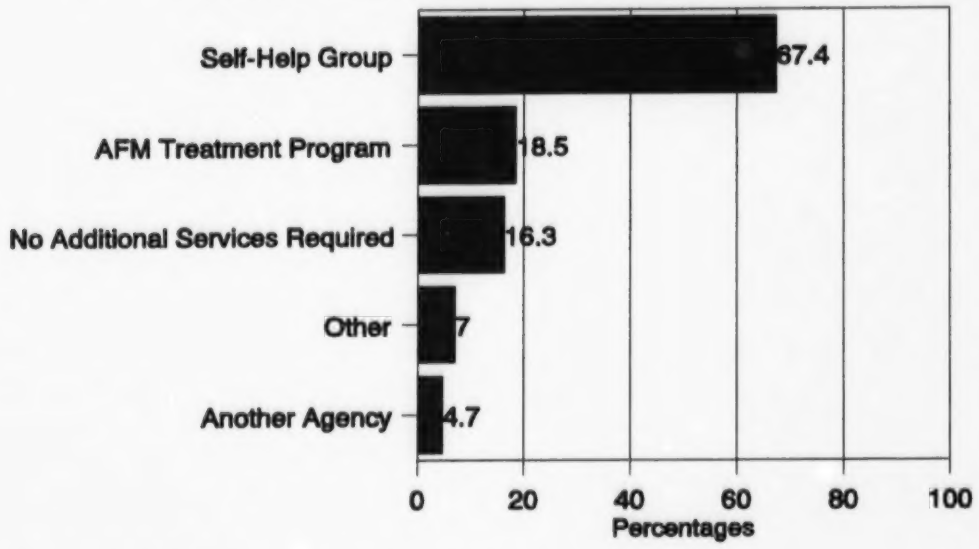
(N=124/344; 40/99; 16/5. Based on partial data collected from 1998/99 client assessment modules and closure forms)

3.3) Referrals Made Upon Exit:

Of the 43 clients for whom information is available, the counsellor felt that no additional

referral was required following the program in seven cases (16.3%) (Figure 26). Another two-thirds of these clients (67.4%) were referred to self-help groups, while 18.5% were referred to AFM treatment programs, and 12.4% (n=4) were referred to other agencies or programs.

Figure 26 Counsellors' Referrals Following Clients' Exit From The Program



(N=43. Multiple Responses Are Allowed.)

CHAPTER FIVE
EVALUATING CLIENT SATISFACTION WITH THE COMING-TO-TERMS PROGRAM

I) BACKGROUND:

This chapter explores respondents' perceptions of the Coming-To-Terms Program. The information reported in this chapter is derived from the satisfaction questionnaire that clients completed upon exiting the program. This includes:

- Their learning experiences;
- The extent to which they believe their goals will be achieved;
- The extent to which they believe their problems are under control;
- An evaluation of the services they received; and
- A global evaluation of their perceptions of the program.

II) WHAT CLIENTS FELT THEY GAINED THROUGH THE PROGRAM:

2.1) Evaluating Learning & Personal Development Experienced By Clients Through The Program

Clients were presented with a list of five elements incorporated within the Coming-To-Terms Program. They were then asked the degree to which they believed they had achieved each of these as a ***direct result*** of the program. These included:

- Learning healthier ways to cope or resolve their problems;
- Feeling better about themselves (self-esteem);
- Developing a plan of action they feel they can achieve;
- Being able to identify their personal substance abuse issues; and
- Developing a Life Area Map that helped them identify these issues.

Measures of satisfaction are quite different from outcome measures. In terms of the former, respondents provide their ***perceptions*** regarding progress made through the program. In terms of the latter, actual ***change is measured over time*** with regard to client functioning (etc.). For example, when clients report they have learned healthier ways of coping, this does not necessarily mean they have incorporated healthier coping strategies into their lives. What it ***does*** indicate is the degree to which they feel they have gained, or grown, in this respect. For ease of analysis, responses have again been converted into their numeric equivalents, and average scores have been provided.[9]

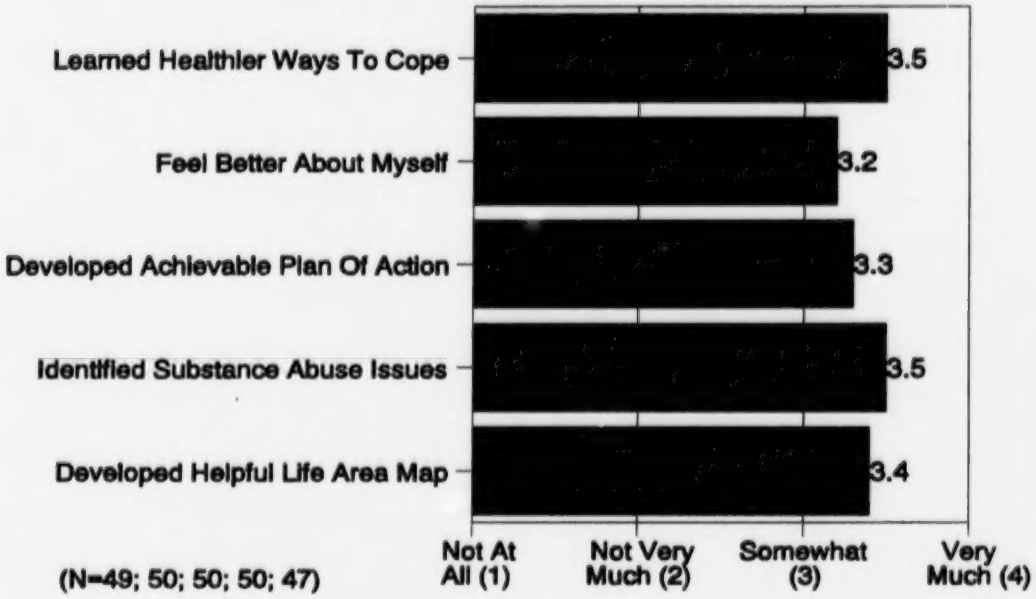
In all cases, average scores, in the aggregate, exceeded 3.2 out of a possible 4.0

---

[9] In this case, a response of 'Not At All' is scored as 1; 'Not Very Much' is scored as 2; 'Somewhat' is scored as 3; and 'Very Much' is scored as 4. Statistical tables, providing frequencies and percentages, are included as an appendix to this report.

(Figure 27). This indicates, overall, that respondents felt they more than somewhat achieved learning objectives. Respondents were most likely to report *learning healthier ways to cope* (3.5); being successful in *identifying their substance abuse issues* (3.5); and believing that their *Life Area Maps had helped them* in this regard (3.4).

Figure 27 Clients Evaluating Their Learning Experiences Through The Program



Responses By Stages Of Change:

With one exception, there was no statistical relationship between the degree to which respondents reported gaining through the program and their respective stages of change upon exit (Figure 28; Table 2). From a statistical perspective, there were significant variations in responses with regard to their learning healthier ways to cope, although no obvious trends emerged regarding this item (i.e. respondents in the Precontemplative, Preparation and Actions stages were generally equally as likely to report learning healthier coping strategies). This trend emerged with respect to clients reporting the development of an achievable plan of action, although these differences are not considered statistically significant.

In terms of face validity,[10] both Precontemplative and Contemplative respondents were relatively less likely to report feeling better about themselves following the program, while those in the Action stage were most likely to do so.

[10] ***Face Validity*** refers to the process of determining programmatic significance of study findings, regardless of the fact that no statistically significant differences emerged.

Figure 28 Clients Evaluating Their Learning Experiences By Stages Of Change On Exit

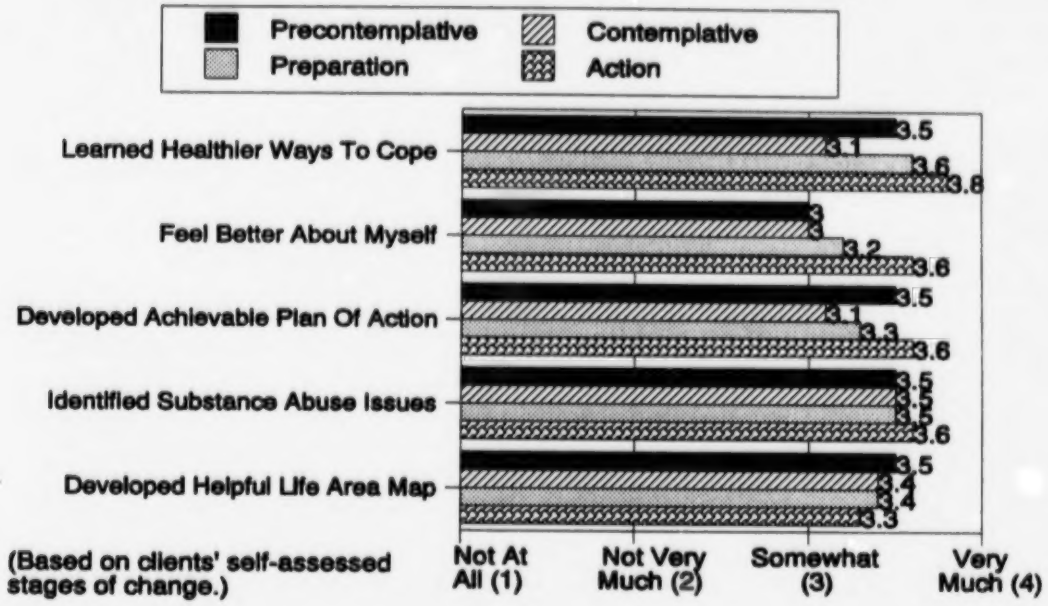


Table 2) Relationship Between Extent To Which Respondents Felt They Gained Through The Program And Their Self-Assessed Stages Of Change Upon Exit[11]

STATEMENT	N	F	df	p
Learned healthier ways to cope	48	3.78	3	.017
Feel better about myself	49	1.92	3	.139
Developed an achievable plan of action	49	1.63	3	.196
Identified my substance abuse issues	49	.271	3	.85
Developed a Life Area Map that helped identify my issues	46	.084	3	.97

2.2) Respondents' Confidence Following The Program:

Respondents were asked two questions indicative of their self-confidence:

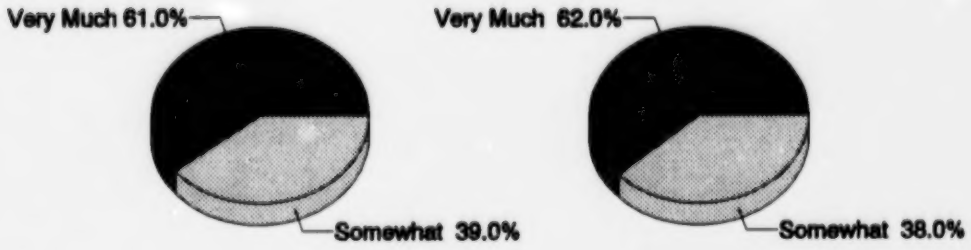
- **Do they feel they will be able to achieve the goals they set through the program?**

[11] The information provided in Tables Two and Three reflect statistical measures related to ***Analysis Of Variance*** **(ANOVA)**. This test is used when comparing test scores or average responses among three or more subsets.

- **Are they confident that their problems are now under control?**

All respondents felt they will be able to achieve their goals, at least 'somewhat.' Of these, 61.0% felt they would be 'very much' able to do so. Similarly, all respondents were at least 'somewhat' confident that their problems were under control upon exiting the program, and 62.0% felt they were 'very much' under control (Figure 29).

Figure 29 Evaluating Respondents' Confidence Following The Program



Extent To Which Respondents Believe They Will Be Able To Achieve Their Goals (N=41*)

Extent To Which Respondents Are Confident Their Problems Are Now Under Control (N=50)

(*Of those who developed Harm Reduction Goals)

III) RESPONDENTS EVALUATING THE SERVICES THEY RECEIVED:

Respondents were asked four questions regarding their treatment while in the program:

- **Were you treated with respect?**
- **Were you treated honestly and openly?**
- **Were you treated courteously?**
- **Was your confidentiality maintained?**

In all instances, almost all respondents reported they were 'very much' treated with respect, with honesty and openness, and courteously, and that their confidentiality was maintained. Averaging the responses to these questions produced a minimal range of scores: from 3.9 to 4.0 (Figure 30).

Responses By Stages Of Change:

There was not very much variation in these responses when respondents' stages of

Figure 30 Clients Evaluating The Services They Received

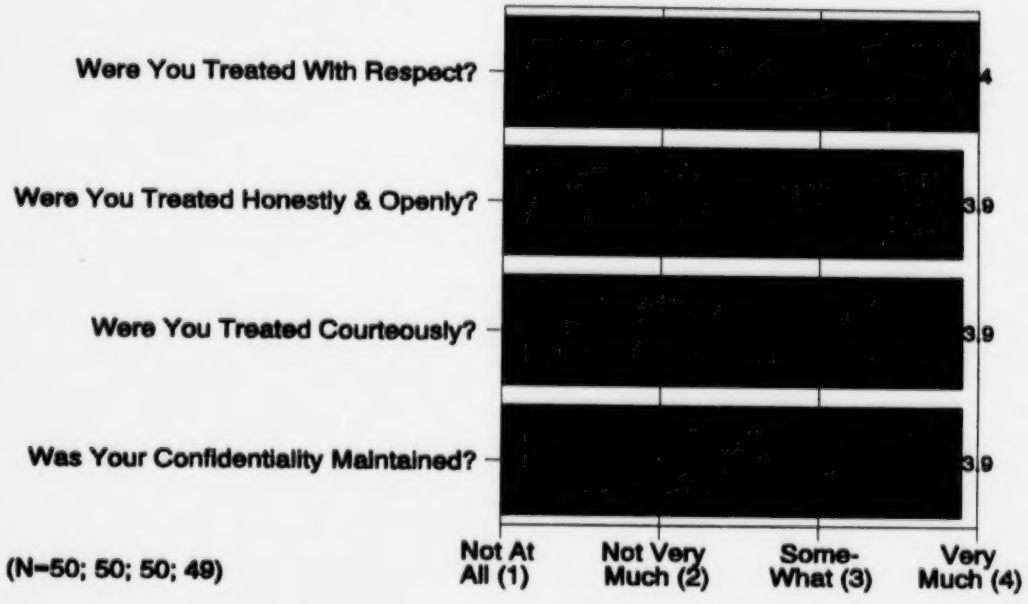
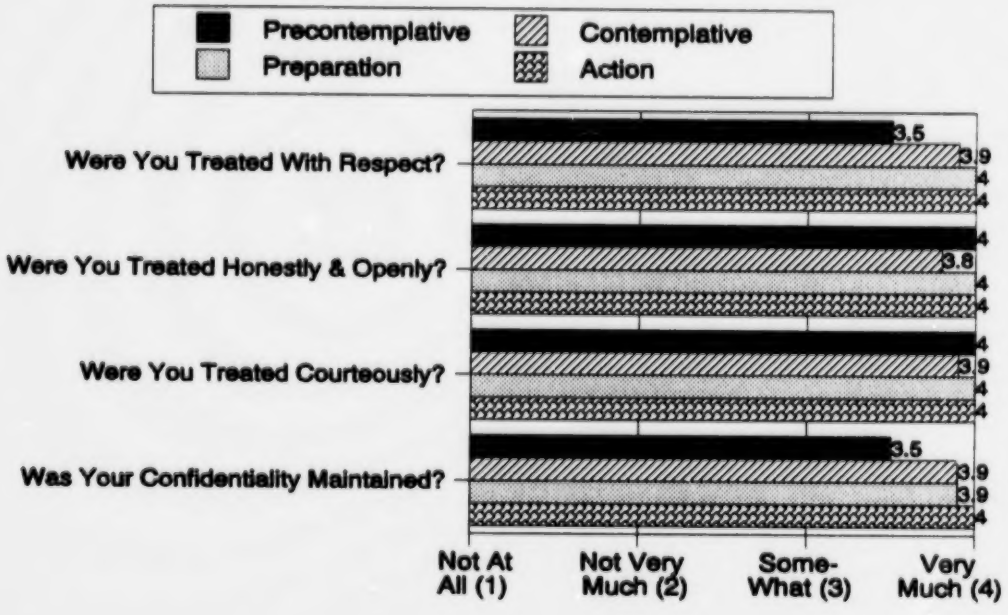


Figure 31 Clients Evaluating The Services They Received By Stages Of Change On Exit



changes are accounted for (Figure 31). For example, when it came to evaluating the extent to which respondents felt they were treated honestly and openly, and the extent to which they felt they were treated courteously, scores ranged from 3.8 to 4.0. This result is expected, given the very positive aggregate average scores recorded regarding these questions.

However, Precontemplative clients were relatively less likely than other respondents to report being treated with respect (3.5), and that their confidentiality had been maintained (3.5). These differences were statistically significant in terms of the former, but not the latter (Table 3).

Table 3) Relationship Between Respondents' Evaluation Of The Services They Received And Their Self-Assessed Stages Of Change Upon Exit

STATEMENT	N	F	df	p
Were You Treated With Respect?	49	5.31	3	.003
Were You Treated Honestly & Openly?	49	1.13	3	.35
Were You Treated Courteously?	49	.396	3	.76
Was Your Confidentiality Maintained?	48	1.81	3	.16

IV) EVALUATING GLOBAL MEASURES OF SATISFACTION:

Three global measures of satisfaction were used in this evaluation, including:

- **Evaluating respondents overall satisfaction with the services they received from the AFM;**
- **Determining whether respondents would use the program again if a similar problem arose in the future; and**
- **Determining whether respondents would recommend the program to a friend or relative who had a problem similar to their own.**

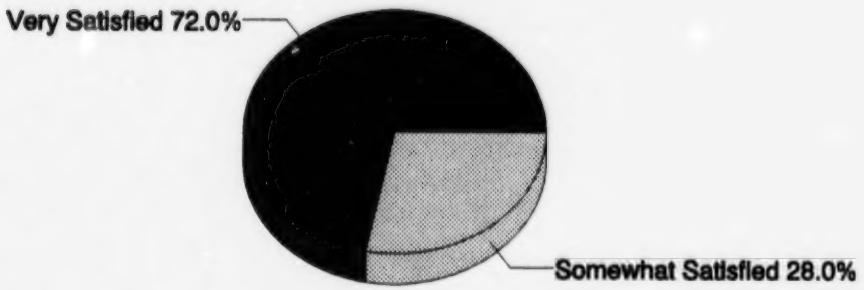
4.1) Measuring Global Satisfaction:

All respondents were at least 'somewhat satisfied' with the services they received from the program, overall, with 72.0% reporting that they were 'very satisfied' in this regard (Figure 32). These responses did not vary significantly when they were correlated with respondents' self-assessed stages of change upon exit.

Respondents' Comments:

Respondents were asked to expand upon their responses. Comment headings included: those who reported learning or gaining insight; those who talked about program accessibility; those who talked about feeling comfortable in the program; and comments regarding positive relationships developed between group members and staffing. There were also a number of themes that included the provision of

Figure 32 Overall, How Satisfied Were Clients With The Services They Received From The AFM?



(N=50)

constructive suggestions for improving the program. These generally related to a request for additional information, more consistency in staffing, questions regarding client anonymity, motivation of other group members, and so. These comments are provided below, organized by theme.

i) **Gaining Insight/Knowledge:**

Learned I had a problem.

I am very satisfied because I've learned a lot of things that I didn't know.

I can say no to drugs, where before I was a pot head.

Got a few tips... There is help if needed.

ii) **Program Accessibility:**

The program (was) available immediately... Good program for my stage (of change).

Program I attended and appointments were easy to participate in.

iii) **Being Comfortable With The Program:**

Even though we sat as a group and discussed issues, I was

encouraged that you find my own comfort zone and a plan to stick to it.

I felt comfortable and able to speak with confidence in the group.

iv) Making Positive Contacts:

Get to know about the other person in the group about her side of her drinking, and ways that we could help one another.

v) A Desire For More Information:

Two respondents implied that there is a need for either more information about the implications of alcohol or other drug consumption and recovery, or an increase in the amount of work clients are expected to undertake.

I liked the group but I now have to devise a plan of action not knowing a lot about the subject.

Feel that there could be more assignments.

vi) Staffing Issues:

One respondent had some concerns about switching counsellors during the program, although it appears this individual was able to successfully adapt to this situation.

vii) Other Concerns:

Six additional concerns were raised, each by a single respondent. These included one individuals who was concerned about providing identifying information; an individual concerned about the apparent lack of motivation of other program participants; a respondent who felt the need for more consistency in AFM staffing; one who felt that he/she was unable to deal with his/her own issues, given the amount of information covered during the program. Finally, one respondent suggested increasing the amount of information provided through the program, while another suggested increasing the length of the program by a couple of weeks.

As an individual who sought out your services on my own, I would rather not have filled out forms and signed my name. I don't see how there can be confidentiality once you have a file on someone.

I think attending the group is important. I was disappointed that those who made up the group were not all committed to the supposed purpose to coming to terms. Mixing judicial situations with those who came on their own volition limited the depth of the group.It was difficult to pre-meet with one counsellor and continue with another, but once past that (I met privately with counsellor) I was satisfied with the expertise and method used.

Information received was too extensive to dwell on own issue.

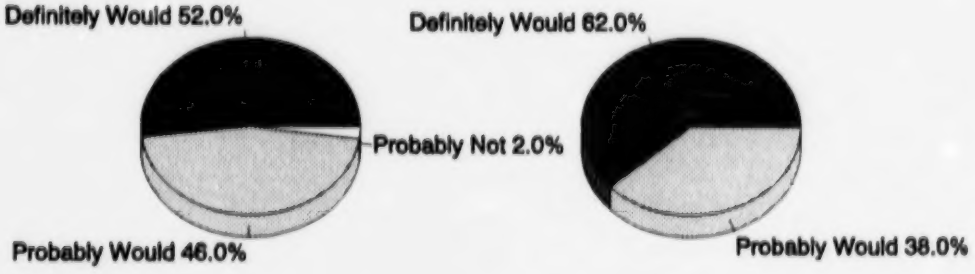
More information/discussion on psychological/historical factors that may have played a part in where individuals were in their personal use pattern.

Allow 2-3 extra weeks to help the people who want help devise a plan of action and/or help people further realize their problem. This is a good, honest, courteous and fair place to come for help.

4.2) Intentions To Use The AFM In The Future:

Almost all respondents stated they would either probably, or definitely use the AFM again if a similar problem arose for them in the future (46.0% and 52.0%, respectively) (Figure 33). One respondent indicated s/he would probably not do so. No significant differences emerged by stage of change.

Figure 33 Evaluating Respondents' Future Intentions Regarding The AFM



Would Respondents Use The AFM In The Future If A Similar Problem Arose? (N=50)

Would Respondents Recommend The AFM To A Friend Or Relative With A Similar Problem? (N=50)

4.3) Intentions To Recommend The AFM To Others:

The last question in this series asked respondents if they recommend the program to a friend or family member with a problem similar to their own. All respondents said that they would, with 38.0% stating they probably would do so, and the remaining 62.0% stating they would definitely do so. As with the preceding two questions, respondents' stages of change upon exit was not a factor in their responses.

Respondents' Comments:

Respondents were asked to expand on their future intentions regarding the AFM. These related both to their own intention to use the AFM again, if the need arose, or to refer a friend or relative to the AFM. In qualifying their responses, a number of respondents cited their feeling that the program had been beneficial to them and those who would recommend the program to others.

i) The AFM/Program Helps:

AFM is there to help and if someone needs help that's their job.

AFM is run and directed by people who know a lot about the problem, and they open it to people easily.

The fact that many people have problems was both comforting and discomforting. But the realization that we all are here to solve or prevent problems with addiction is good!

I found the program helpful. The information useful and I greatly appreciate it.

I learned a lot from (the counsellors).

I appreciated the more direct approach that you, _____, provided. It moved the group in a more direct way and brought out more human issues/barriers.

This is a good program. I like it.

I feel that this worked very well for me and that I understand more about my life and how to control or deal with it.

Because I have received education which I believe is beneficial and think it would help others.

It was a good program and it was satisfied to myself and I will tell others.

AFM made me see the light, I'm sure it would help anyone else.

This is by far the best method to the goals of getting substance abuse under control ie. group sessions, one on one with counsellor.

Reasonable approach to the situation, staff understood the issues and treated all parties with respect.

ii) Respondents Who Would Recommend The AFM:

A couple of the respondents who talked about recommending the AFM did so without qualification. However, most did qualify their comments. Some of the unqualified comments included:

If after being at these meeting I have a friend that I think would benefit from outside help to either abstain or control I would suggest

what I've just gone through and explain how beneficial it has been in terms of even just opening my eyes to the problem.

It's a good program with good people here to help - I would recommend it to friends/family.

Some of the qualifications provided referred to the need for people to be ready to make use of an organization like the AFM. The intent seemed to be that there was no point recommending the AFM to people who were not ready, or open to the suggestion.

(I would return)...if I had time to attend a program in the future, because I am quite busy with my kids when they're with me. I tried to recommend my daughter and family about the program, but they seem to say 'I don't like to talk to anybody about my problem' -daughter said- or family interested but later on, not now.

I have friends and relatives that do a lot of drinking. I'll try and explain to them, all about AFM. But then again, I don't think they would try anything for their problems.

Two respondents felt they did not have the right to interfere in someone else's decisions regarding treatment.

If I had a problem I would come here for help. I don't feel that I have the right to refer anyone here.

...Let others make their choice through information.

Another respondent commented on the AFM's stigma, and his/her preference to rely more on self-help groups and private counsellors.

Unless someone had absolutely no alternative but to go to AFM. I would rather suggest personal counselling and going to AA meetings. There's too much stigma surrounding the issue and the Foundation.

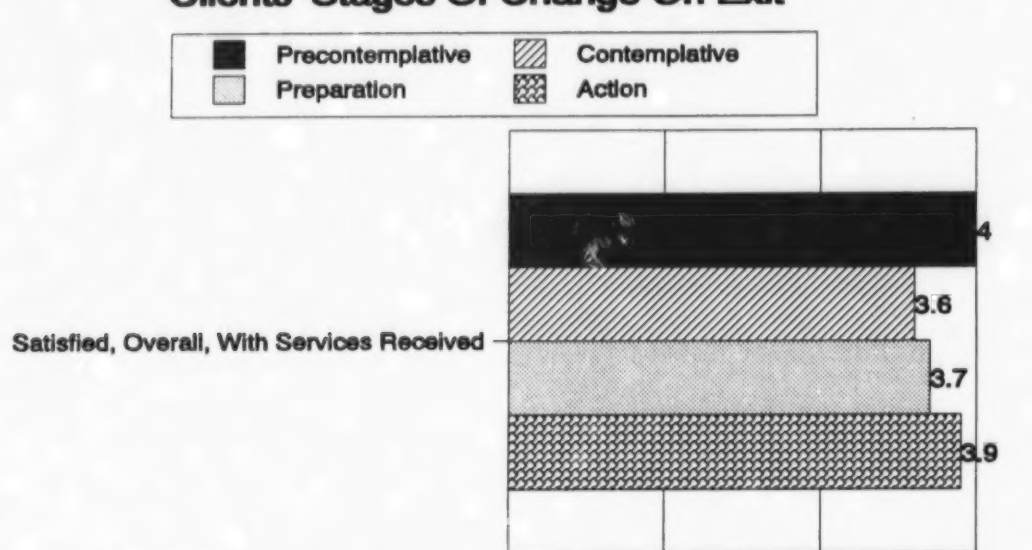
Finally, one respondent reported that he/she would likely return to the AFM if the need arose.

If it gets out of hand I will commit myself.

4.4) Global Satisfaction Measures By Stages Of Change:

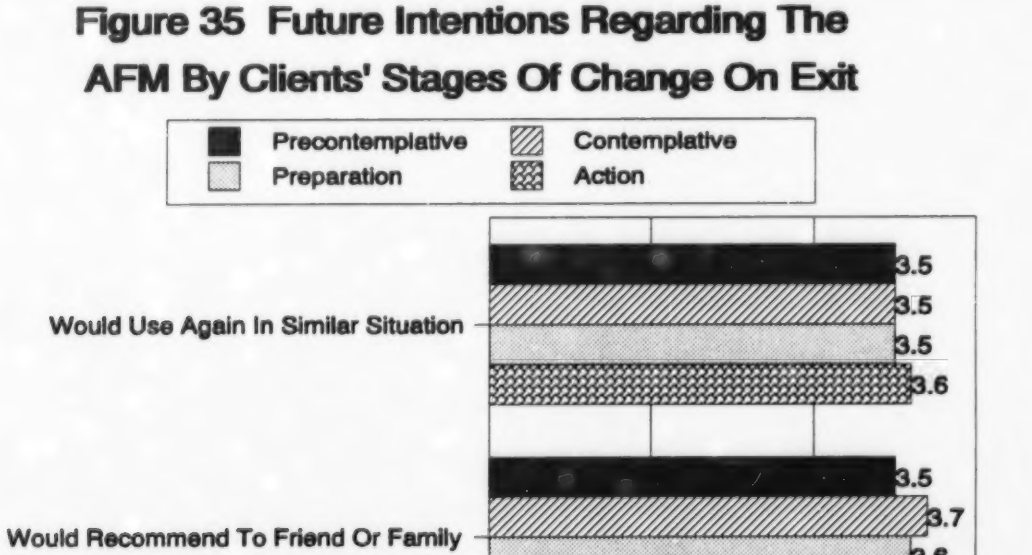
There appear to be relatively few differences in these responses when they are analyzed by respondents' self-assessed stages of change. Respondents, regardless of their stages of change, were equally as satisfied with the overall services they received (Figure 34). Average scores ranged from a relative low of 3.6 to 4.0,

Figure 34 Global Satisfaction Measures By Clients' Stages Of Change On Exit



(Based on clients' self-assessed stages of change.)

Figure 35 Future Intentions Regarding The AFM By Clients' Stages Of Change On Exit



(Based on clients' self-assessed stages of change.)

indicating that respondents, across the stages, were generally more than just somewhat satisfied with the services they received through the AFM.

The same can be said in terms of respondents' future intentions regarding the AFM (Figure 35). With respect to respondents' intentions to use the AFM again if a similar problem arose, the average responses ranged minimally from 3.5 to 3.6, with 4.0 indicating respondents' intention to 'definitely' use the AFM again. Similarly, there were no significant differences, by stage of change, regarding the extent to which respondents would recommend the AFM to a friend or relative with a similar problem to their own. In this instance, average responses ranged from 3.5 to 3.7.

Table 3) Relationship Between Respondents' Global Evaluation Of The AFM And Their Self-Assessed Stages Of Change Upon Exit

STATEMENT	N	F	df	p
Overall how satisfied were you with the services you received from the AFM?	49	1.13	3	.35
Would you use the AFM in the future if a similar problem arose?	49	.083	3	.97
Would you recommend the AFM to a friend or relative who had a problem similar to your own?	49	.297	3	.83

CHAPTER SIX
STAFF EVALUATING THE COMING-TO-TERMS PROGRAM

I) BACKGROUND:

The final area of analysis examines AFM staff perceptions of the Coming-To-Terms Program. Keeping in mind the range of expectations that staff and managers had while the program was being designed, it is important to determine the extent to which these individuals felt these expectations have been attained.

1.1) The Effect Of Sample Size:

One problem in this analysis is the small number of individuals qualified to respond. Participation in this component of the study was limited to those individuals who had first hand experience with the program. This includes those facilitating the program, or those providing services to clients falling outside the program and/or making referrals to the program. The result is a sample of four respondents. These individuals were responsible for a total of 94 referrals to the program: an average of 23.5 referrals.

1.2) Areas Of Inquiry:

This component of the overall evaluation subsumes five areas of inquiry:

- whether staff believed the objectives related to clients in standard AFM groups (i.e. excluding Precontemplative and Contemplative clients) achieved the objectives that were established for these individuals.
- Whether staff believed the objectives related to clients participating in the Coming-To-Terms program achieved the objectives established for this program.
- Whether staff felt the program had been successful to date, overall.
- Staff perceptions regarding the programs strengths and limitations.
- What advice staff would give to others who were thinking of establishing a program similar to Coming-To-Terms.

II) STAFF EVALUATION RESULTS:

2.1) Objectives Achieved Regarding Clients In Other Programs:

Staff evaluated the extent to which four program objectives, regarding the benefits to clients attending regular programs, had been achieved. These included:

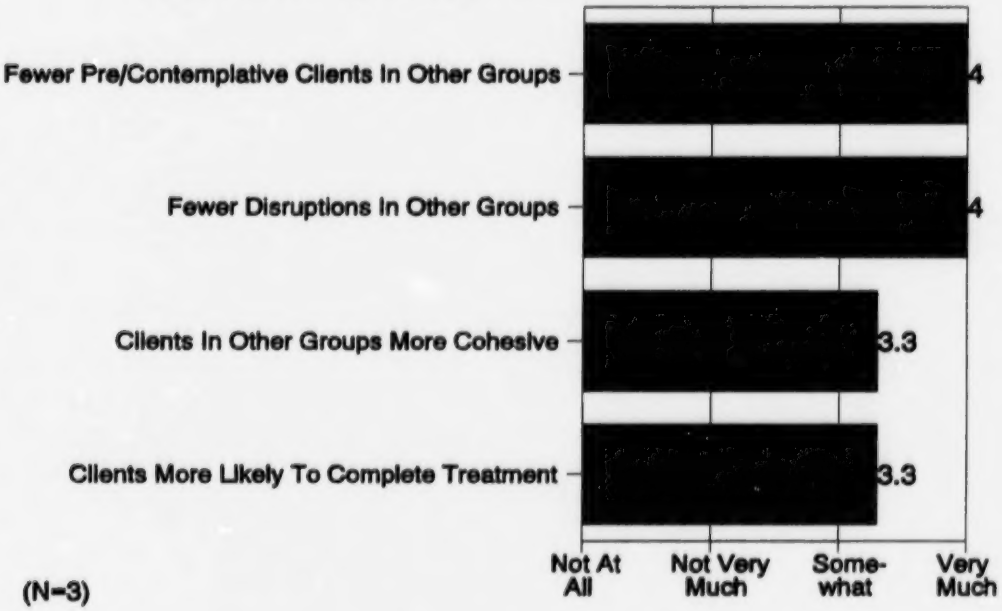
- There will be fewer Precontemplative/Contemplative clients in groups with other clients.
- There will be fewer disruption in other (non-C-T-T) groups (i.e. groups with no Precontemplative and Contemplative clients).
- Clients in other groups will be more cohesive.

- Clients in other groups will be more likely to complete treatment than they were when Precontemplative and Contemplative clients were in group with them.[12]

Staff were asked to rate the extent to which they personally felt each of these four points had been achieved, using a four-point Likert scale. Possible responses ranged from *Not At All* (scored as '1'); *Not Very Much* (scored as '2'); *Somewhat* (scored as '3'); and *Very Much* (scored as '4'). Given the limited number of respondents, these findings are presented as average scores.

There were two objectives which all staff respondents felt had been very much achieved for the non-Precontemplative and non-Contemplative groups: these remaining groups did appear to be have none of these clients in them, indicating that the screening and referral process appears to have been very effective (Figure 36). As a possible corollary, all of these respondents very much reported that there had been fewer disruptions in the remaining groups.

Figure 36 Staff Assessment Of Whether Program Achieved Objectives For Other Groups



To a somewhat lesser extent, staff felt that the remaining groups showed evidence of greater cohesion (with an average score of 3.3 out of a possible 4.0); and that clients in these groups were more likely to have completed treatment than might have otherwise been the case (3.3).

[12] Two other objectives were in the staff Program Evaluation questionnaire. However, they were only answered by a single staff respondent and have therefore been excluded from this analysis.

2.2) Objectives Achieved Regarding Coming-To-Terms Clients:

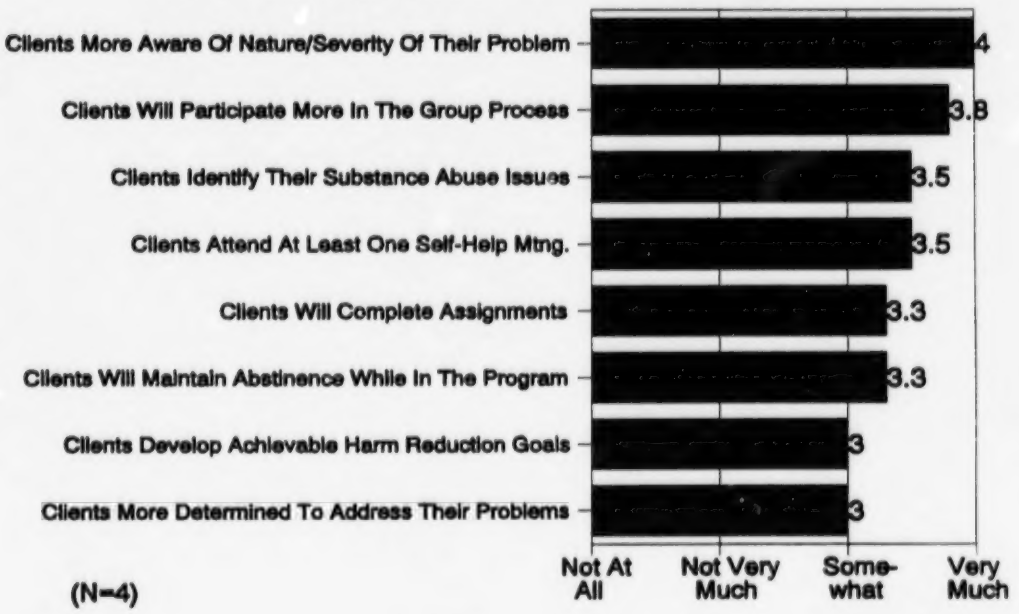
There were four specific objectives directed toward clients participating in the Coming-To Terms Program. Specifically, objectives related to these clients:

- Participating in the group process;
- Completing their assignments;
- Maintaining abstinence throughout the program;
- Attending at least one self-help group meeting while attending the program;
- Developing achievable harm reduction goals;
- Being able to identify their substance abuse issues;
- Being more aware of the nature and severity of their chemical problems;
- Being more determined to address their alcohol and/or other drug problems.

While some of these questions have already been addressed in terms of specific clients, this is the only opportunity these staff had to summarize their perceptions for these clients as a whole.

From the data, it is apparent that most of these objectives have been more than somewhat achieved, at least from the staff perspective (Figure 37). Overall, all staff felt that these clients had become very much aware of the nature and severity of their

Figure 37 Staff Assessment Of Whether Program Achieved Objectives For C-T-T Groups

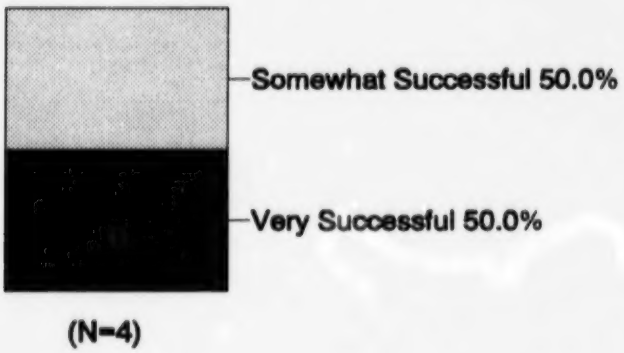


problems (with an average score of 4.0). They generally also felt that these clients had very much participated in the group process (3.8); that they were able to identify their substance abuse problems (3.5); that they attended at least one self-help group meeting while in the program (3.5); and, to a somewhat lesser degree, that they completed their assignments and maintained abstinence while in the program (3.3). On average, these staff felt that program clients were somewhat able to develop harm reduction goals and that they were more determined to address their problems (3.0).

2.3) Staff Evaluating Global Program Success:

Staff were presented with the following question: *Overall, how successful do you feel the Coming-To-Terms Program has been so far?* Two of the four staff respondents felt the program had been very successful so far, while the other two felt it had been somewhat successful (Figure 38).

Figure 38 How Successful Do Staff Feel The Program Has Been So Far?



Related Staff Comments:

Staff respondents were asked to expand upon their responses. Three of the four comments are provided in the context that this program was never designed as a treatment program, but is more of an educational and secondary prevention initiative. Most of the comments reinforce the impression that the Coming-To-Terms program has succeeded in this respect.

(The program has been) successful as clients (are) not ready to

address (their) illness... Gave them more awareness & better choice to make decisions regarding treatment. Also good referral for most mandatory clients and at least they had a starting place.[13]

The program was developed to meet the needs of a specific group of clients and the contents and approach were tailored to meet these identified special needs.

Provides client with information to make further self assessment. We ask client to abstain & they get a sense of how easy or difficult that maybe. Introduces them to AA. Allows them to converse with others who aren't sure where they are at re: alcohol/drug use. The opportunity to meet with counsellor pie & post group sessions.

One staffperson appeared concerned that some clients who could benefit from the program did not have the opportunity to access it.

There still appears to be a reluctance to refer clients to Coming-To Terms.

2.4) Staff Perceptions Of Program Strengths:

When staff identified the strengths of the Coming-To-Terms Program, three of these four staff talked about the educational orientation of the program. This was seen as more appropriate than a traditional treatment approach, given that these clients had not yet determined whether or not they had a chemical problem.

Program designed with Adult Learning Principals Concept. An Educational approach was utilized. Clients were met where they were at. Clients opinion & insights validated. A Harm Reduction Concept was utilized.

Provides information in a non-judgmental way. Encourages client involvement and participation. Meets a need that people don't have to fall through the cracks (eg. not ready for treatment program)...

More awareness for client. Giving them another option besides treatment.

A fourth staffperson talked about the positive aspect of dividing clients based on their readiness to change.

---

[13] Text provided in bold italics represent verbatim comments.

Keeps resistant clients out of the treatment process which in turn may produce more effective Treatment groups. Focuses specifically on breaking-down resistance.

2.4) Staff Perceptions Of Program Limitations:

When these same staff were asked what they saw as the program's limitations, a wider range of responses resulted. One staffperson felt that the program should be run more often, and that the limit of one program per month was insufficient; two staff reported the need to simplify written portions of the program; while a third staffperson talked about a shortage of staff who have been trained to work with this client population.

Only running one program per month, if closed (program), limits number of clients able to access long waiting period.

May need to simplify written; (the) Harm Reduction Plan.

Clients need to have a fairly good level of comprehension and be able develop achievable goals.

Not sufficient staff trained (available) with program.

A fourth staffperson identified two concerns: the need to ensure that staff in this program have the opportunity to work with other clients as well; and the fact that clients entering regular program streams may find some of the material redundant.

For counsellor with caseload of only precontemplative and contemplative clients it can be draining. (You) don't have the opportunity to see major changes.

If client decides to go to nonresidential treatment some information maybe repetitive.

III) STAFF ADVICE TO OTHERS CONSIDERING IMPLEMENTATION OF A SIMILAR PROGRAM:

Given the formative nature of this evaluation, a group process was held involving the three AFM staff who were most involved with the design and initial implementation of the Coming-To-Terms Program.[14] Discussions throughout this process focused on one primary question: *if you were talking to a colleague from another organization, what advice would you give them regarding establishment of a program like this?* The following represents the content of this process.

---

[14] This meeting, which took place July 20th, 1999, involved **Mr. Barry Henrikson**, former supervisor of the program, **Ms. Karin Archibald**, current counsellor running this program, and **Mr. Paul Barton**, former counsellor with the program. Additional related comments were taken from a staff survey.

Comments fell within the following ten themes:

- **Staff being aware of the Stages of Change Model**
- **Referral sources being familiar with the program**
- **Be selective in the clients accepted into the program**
- **Keep control of the waiting period**
- **Staff facilitating the program should be comfortable with the program's philosophy and objectives**
- **Ensure the program is adequately staffed**
- **Monitor program process and content**
- **Limit group size and format**
- **Limit program duration**
- **Conduct a needs assessment**

i) Staff Being Aware of the Stages Of Change Model:

Staff consistently the reported the need for staff to have good working understanding of the ***Stages of Change Model*** for a program such as Coming-To-Terms to work well. This was perceived as important both for counsellors facilitating the program and for those, in other programs, who were providing referrals. Otherwise, there was concern that inappropriate referrals would be made.

ii) Referral Sources Being Familiar With The Program:

As well as being familiar with the Stages Of Change model, staff felt it essential that potential internal and external referral sources be familiar with the program, who it is designed to serve, and the program's goals and objectives. Referral sources should be provided with information establishing criteria for appropriate referrals. In addition, it is incumbent on program staff to ensure that potential referral sources are aware of the benefits of the program for their precontemplative and contemplative clients.

iii) Be Selective In The Clients Accepted Into The Program:

Some staff also felt that not all precontemplative clients are necessarily appropriate referrals to the program. This should be limited solely to those who could benefit from attendance, excluding nonparticipant clients who really do not want to be there.

As well, staff felt that clients need good written and oral skills to benefit from this program, given its use of written materials.

iv) Keep Control Of The Waiting Period:

Of all clients attending programs, precontemplative clients are going to be least tolerant of an extended waiting period. The sooner these clients can be engaged in a program, the more likely they are to attend it.

v) Staff Facilitating the Program Should Be Comfortable With The Program's Philosophy and Objectives:

Not all staff are appropriate to facilitate this type of program. Given the nature of the clients attending the program, and the fact that many of these have not really accepted their need to change their behaviour, this experience could be trying for some counsellors. The advice from the current staff is that counsellors have to believe in the value of nontraditional approaches: including non-therapeutic, educational approaches. The orientation of this process is almost wholly educational.

In a similar vein, staff advise that traditional treatment approaches are ineffective for this client population. Instead, the counsellor must "guide the client on a voyage of discovery." Conversely, a "strong confrontational approach" will be totally ineffective. The focus, instead, is on a variety of techniques employed to break barriers; to set the stage for subsequent therapeutic involvement. The key, according to these staff, is to "accept clients' self perceptions, but gently assist them to gain insight" into their own behaviour and its ramifications.

vi) Ensure The Program Is Adequately Staffed:

Given the nature of the clients involved in this program, it is deemed essential that programs, such as Coming-To-Terms, be adequately staffed. Depending on the size of the group, and the level of commitment clients have to this process, it may be necessary to use group co-facilitators.

In addition, as one staffperson noted, "during times of vacation or illness, the program should not have to be dropped because the counsellor is away."

vii) Monitor Program Process And Content:

Staff were asked to consider the current curriculum for this program. Overall, they felt that the development of a Harm Reduction Plan for each client was "awkward and too treatment-oriented" for this program. They were quite comfortable with the remaining program content.

They felt it was important that clients be made aware of expectations for group involvement right from the beginning, as this is central to the success of the program. They similarly believed that all clients should have a clear understanding of program rules, and the consequences associated with breach of the clients' contract with the program.

viii) Control Group Size And Format:

Staff recommend that group size be limited between 8 and 9 clients. This is viewed as ideal for encouraging discussion, while retaining an informal feeling. As well, staff recommended closed groups as another means of enhancing group cohesion and the likelihood that group members will feel freer to share their feelings.

ix) Control Program Duration:

In terms of process, the current session of 4 groups and 2 individual sessions for each client was deemed appropriate. They felt this provided "enough time considering what

we wanted the program to do." This limited timeframe is an important feature of the program. If one starts from the premise that many of these clients do not even accept that they have an alcohol or other drug problem, they will be more likely to complete a program that is of limited duration.

x) Conduct A Needs Assessment:

Finally, staff consistently felt that organizations should conduct needs assessments as part of their planning process, when it comes to designing programs for precontemplative and contemplative clients. Program design and development should be based, in part, on client assessments & referrals. Some of the questions that can be included in a needs assessment are provided below.

- How great is the need for this type of program?
- Are there alternative programs available in the community?
- How many precontemplative and contemplative clients are there in current programs?
- Is the presence of these clients an issue for staff?
- Are precontemplative and contemplative clients disruptive to group processes for other clients?
- Do staff have the right training and understanding of the Stages of Change Model, or is additional training required?

CHAPTER SEVEN
STUDY CONCLUSIONS

The Coming-To-Terms Program was established with four objectives in mind:

- Participants will complete their personal life area map reflecting consequences of their chemical usage.
- Participants will identify their stage of change in relation to their self-assessment of chemical usage.
- Participants will develop written harm reduction goals.
- Participants will develop a written time-framed action plan to achieve their identified goals.

In addition, there were five expectations placed upon program clients:

1) They are expected to maintain their abstinence throughout the program.
2) They are expected to attend at least one self-help meeting during the program.
3) They are expected to attend all program sessions, as scheduled.
4) They are expected to participate in group discussions.
5) They are expected to complete all assignments arising from the program.

The extent to which this pilot phase of The Coming-To-Terms Program was a success is based on the extent to which these objectives and expectations were achieved.

I) CLIENT DEMOGRAPHICS:

There were no notable variations in the profiles of Coming-To-Terms clients and those in other programs, with respect to gender, age and education. However, clients referred to the Coming-To-Terms Program were more likely to have been referred to the AFM by corrections, and were similarly less likely to report being self-referred. In addition, clients in the Coming-To-Terms Program were also less likely to report a number of symptoms, related to their consumption, than were their counterparts. This was true with regard to clients reporting: shakes or tremors, nervousness, restlessness, cold sweats, feeling weak all over, rapid heart beat, difficulty breathing, and hearing and seeing things that were not really there.

Conclusion 1: ***There may be some empirical differences with regard to clients in these two groups, related to the effects they experience due to their consumption. Those in the Coming-To-Terms Program appear to have fewer effects due to consumption.***

II) MEETING PROGRAM OBJECTIVES:

Based on the data, clients reported achieving all of the objectives established for the program. This includes developing life area maps, identifying their respective stages of change with respect to their self-assessment of chemical usage, and writing harm reduction goals. The majority of the respondents who developed harm reduction goals reported that their goal was abstinence (54.8%). Another 42.9% of these respondents reported their goal was reduced consumption. Responses did not vary significantly when respondents' stages of change were taken into account.

To a somewhat lesser degree, clients in the study reported developing achievable plans of action. Overall, these findings were corroborated by the counsellors, who reported on the progress made with regard to each of these clients. Not surprisingly, clients assessed by their counsellors as being in the Preparation or Action stages, upon exit, were most likely to report achieving these objectives. However, all clients, reported some progress in this regard.

Conclusion 2: ***Based on the findings, the objectives established for this program were achieved by most program clients. The extent to which this occurred varied somewhat by clients' assessed stage of change upon exit.***

III) MEETING PROGRAM EXPECTATIONS:

Counsellors reported that their clients generally met all of the expectations established by the program. In eighty percent of the cases, they reportedly maintained abstinence through the course of the program. Additionally, about 84% of these clients attended at least one self-help meeting, just under 60% of these clients reportedly participated "very much" in group discussions, while another 31.8% "somewhat" participated, and half of these clients "very much" completed all of their assignments, while another 45.5% "somewhat" completed assignments.

Conclusion 3: ***Based on the findings, program expectations were generally met by program participants. Once again, clients' respective stages of change, upon exit, was a factor regarding the extent to which this occurred.***

IV) OTHER PERFORMANCE MEASURES:

In addition to these formal measures, several others can be applied to this study:

- Client completion rates;
- Client movement regarding their personal Stages of Change;
- Perceived impact on clients in other programs;
- Client satisfaction with the program.

4.1) Completion Rates:

By definition, Precontemplative and Contemplative clients are assumed to be less likely to complete their rehabilitation program than are clients who are in the Preparation or

Action stages. After all, they generally don't believe or accept that they have a problem requiring treatment or rehabilitation. The rates of completion, among Precontemplative clients in other Winnipeg-based AFM rehabilitation programs was 22.6%. Similarly, the completion rate for Contemplative clients in these programs was 28.5%. In contrast with these figures, the completion rate of Precontemplative clients in the Coming-To-Terms Program was 37.5%, with a 40.0% completion rate for Contemplative clients.[15]

Conclusion 4: ***Based on these findings, it is concluded that the completion rate was notably increased for Precontemplative and Contemplative clients in the Coming-To-Terms Program, as compared with their counterparts in other AFM Adult Rehabilitation Programs.***

4.2) Stages Of Change:

An equally important performance measure is the degree and direction of change experienced by these respondents. The program is educational in nature. At its base is the aim of providing clients with the information and insight required to come to terms with their chemical problems: to understand and accept their levels of involvement and substance abuse issues. The extent to which this occurs is the extent to which clients move along the continuum of change.

All clients entering this program were at the Precontemplative or Contemplative stage of change. Upon exiting the program, only 11.6% of these clients were assessed by their counsellors as remaining in the Precontemplative stage. Of the remainder, 27.9% were assessed as being Contemplative, 48.8% were felt to be in the Preparation stage, and 11.6% were assessed in the Action stage. These views were corroborated, overall, by clients' own self-assessments.

In 86.0% of the cases, clients progressed along the continuum. The largest percentage of clients (30.2%) progressed from the Precontemplative to Preparation stages during the course of the program. Another 25.6% progressed from the Precontemplative to Contemplative stage of change, while 18.6% progressed from the Contemplative to Action stage.

In four cases (11.5%), clients remained at the same stage at which they entered the program. Three of these were at the Precontemplative stage upon entering the Coming-To-Terms Program, while the fourth was at the Contemplative stage. One client regressed from the Contemplative to Precontemplative stage during the course of the program.

Conclusion 5: ***It is concluded that the program has been successful in providing clients with the information and insight they require to recognize that they may have problems related to chemical usage that impact negatively on their lives. However, it is***

[15] This is the assessment of stage of change made by counsellors upon clients' exiting the program.

unknown whether this apparent increase in insight results in changing their related behaviour.

4.3) Impact Upon Clients In Other Programs:

Counsellors outlined the impact they felt that Precontemplative and Contemplative clients had on other clients in groups. Through the inception of the Coming-To-Terms Program, staff predicted four positive outcomes for the remaining clients:

- There would be fewer Precontemplative and Contemplative clients in the remaining groups;
- Clients in these groups would be more likely to complete treatment;
- There would be an increase in group cohesion;
- There would be fewer disruptions in the group process.

Staff also predicted a more positive working environment for the counsellors themselves:

- Staff would be less likely to report frustration, and would experience greater job satisfaction.

Six months following the program's introduction, staff "very much" reported a reduction in the number of Precontemplative and Contemplative clients attending standard groups. To a somewhat lesser degree, they also reported fewer disruptions in their other groups; they reported that these other groups were more cohesive; and that clients in these other groups were more likely to complete the program than they might have been if Precontemplative and Contemplative clients were group members.

As a result, it is inferred that counsellors, facilitating these regular groups, would experience less frustration in this respect, and greater job satisfaction.

Conclusion 6: ***From these findings, it is concluded that counsellors felt that the advent of the Coming-To-Terms Program alleviated some of the negative factors experienced when Precontemplative and Contemplative clients were included in standard groups.***

4.4) Client Satisfaction With The Program:

Overall, respondents were very satisfied with the Coming-To-Terms Program. They felt they had gained new knowledge, learned healthier ways to cope, identified their substance abuse issues, developed a 'helpful' life area map, and developed an 'achievable' plan of action. They also generally reported feeling better about themselves as a result of the program.

In terms of global satisfaction measures, almost three-quarters of these respondents were 'very satisfied' with the services they received through the AFM, while the remainder were 'somewhat satisfied.' They reported gaining insight from the program, liked the degree to which the program was accessible to them, felt comfortable with the program, and reported making some positive contacts. The one area where changes were suggested related to their desire for more information through the program.

Respondents consistently reported they would either 'definitely' or 'probably' use the program again if a similar problem arises, and that they would also recommend the program to a friend or relative with a problem similar to their own.

Finally, respondents were very positive in their evaluation of how they were treated at the AFM. They felt they were treated with respect, that they were treated honestly and openly and courteously, and that their confidentiality was consistently maintained.

Conclusion 7: ***From the data, it is concluded that the respondents to this study were either 'satisfied,' or 'very satisfied' with most components of the Coming-To-Terms Program. This includes their personal development, goal attainment, the services they received, and their global impressions of the AFM.***

4.5) Staff Evaluations Of The Program:

AFM staff who facilitated the Coming-To-Terms Program, and those who facilitated the other rehabilitation groups, believed that this program enhanced the experiences of clients in the Preparation and Actions stages of change. They likewise reported that clients in Coming-To-Terms Program were likely to fulfil program expectations. Finally, they reported that clients in the program progressed along the Stages Of Change continuum.

In terms of satisfaction measures, half of the staff-respondents (n=4) reported that the program has been "very successful" so far, while the other half reported that it has been at least "somewhat successful." From their comments, it is apparent that the program is seen as a viable and desirable alternative for clients who are not yet sure that they have a chemical problem, or that they should seek to change their related behaviour.

Conclusion 8: ***Notwithstanding that there were some program limitations cited by counsellors administering the program, it is clear that these staff were generally very satisfied with program outcomes during its pilot phase.***

APPENDIX ONE

STUDY QUESTIONNAIRES & FORMS

'COMING TO TERMS ' - ASSESSMENT UPON CLOSURE

1) Client Code:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

0	1	2	3	4	5	6	7	8	9

2) File Number:

0	1	2	3	4	5	6	7	8	9

3) Exit Date:

DD		MM		YY	
0	1	2	3	4	5	6	7	8	9

4) How would you have assessed this client's **Stage Of Change UPO N ENTRY?**

○ **Precontempative** ○ **Contemplative**

5) How would you assess this client's **CURRENT Stage Of Change (I.e. UPON EXIT)?**

○ **Precontempative** ○ **Contemplative** ○ **Preparation** ○ **Action**

6) To what degree do you feel this client **participated in the group process**?

○ **Very Much** ○ **Some** ○ **Not Very Much** ○ **Not At All**

7) To what degree do you feel this client **completed his/her assignments**?

○ **Very Much** ○ **Some** ○ **Not Very Much** ○ **Not At All**

8) Do you believe this client **maintained abstinence** throughout the program?

○ **Yes** ○ **No**

9) Did this client **attend at least one self help group meeting** while attending this program?

○ **Yes** ○ **No**

10) To what extent do you believe this client has **developed achievable harm reduction goals**?

○ **Very Much** ○ **Some** ○ **Not Very Much** ○ **Not At All**

11) To what extent do you believe this client was able to **identify their substance abuse issues**?

○ **Very Much** ○ **Some** ○ **Not Very Much** ○ **Not At All**

12) ***What Referrals Were Made? (Please Fill In ALL That Apply.)***

- ○ **No Additional Services Required**
- ○ **Self Help Group**
- ○ **AFM Residential Treatment**
- ○ **AFM Day Treatment Program**
- ○ **AFM Community-Based Program**
- ○ **Another Addictions Agency**
- ○ **Another Agency:** _____
- ○ **Other:** _____

AFM CLIENT SATISFACTION: 'COMING TO TERMS'

Please take a few minutes to complete this form, prior to exiting the Coming-To-Terms Program. The information you provide us will help us to improve the services we provide our clients. **ALL RESPONSES ARE ANONYMOUS. CLIENTS CANNOT BE IDENTIFIED THROUGH THIS FORM.** Please place the completed questionnaire in the envelope provided, and seal it. All sealed envelopes will be delivered directly to the **AFM's Research Unit**.

1) Did you complete this program? ○ **Yes** ○ **No**

1.1) If 'No,' why not? _____

_____

Part One: Please Tell Us A Bit About

2) What is your **gender**? ○ **Male** ○ **Female**

3) What is your **age**? ☐☐

4) What is the highest level of **education** you have attained?

- ○ **Grade 9 or less**
- ○ **Incompete High School**
- ○ **Complete High School**
- ○ **Incomplete Community College/Technical School**
- ○ **Complete Community College/Technical School**
- ○ **Incomplete Undergradua[illegible] Degree [University]**
- ○ **Complete Undergraduate Degree [University]**
- ○ **Graduate Degree**
- ○ **Other :** _____

5) Who referred you to the AFM? ***(Please Fill-in ONE bubble only.)***

○ **Child & Family Services** ○ **Corrections System** ○ **Employer/EAP** ○ **Other:** _____

6) Have you ever **attended a chemical treatment program before**, aside from this one? ○ **Yes** ○ **No**

6.1) If 'YES,' did you complete that program? ***(Note: If you attended more than one program in the past, did you complete the LAST program attended?)*** ○ **Yes** ○ **No**

6.2) If you did not complete that program how much do you believe each of the following factors led to your not completing it? ***(If you completed the last program, please skip to Question 7.)***

REASONS FOR LEAVING EARLY	Very Much	Somewhat	Not Very Much	Not At All
Time or location was not convenient	○	○	○	○
Other factors, outside of the program, interfered (e.g. work/school, home responsibilities, etc.)	○	○	○	○
I was unable to stay sober/straight	○	○	○	○
I didn't feel I was being helped by that program	○	○	○	○
My previous counsellor and I did not get along	○	○	○	○
Other:	○	○	○	○

59439

Part Two: The Services You Received

7) To what extent did you experience each of the following as a ***Direct Result*** of the AFM?

	Very Much	Somewhat	Not Very Much	Not At All
I learned healthier ways to cope or resolve my problems	○	○	○	○
I feel better about myself (self-esteem)	○	○	○	○
I developed a plan of action that I feel I can achieve	○	○	○	○

8) Do you feel you are now able to identify your ***personal*** **Substance Abuse Issues**?

○ **Very Much** ○ **Somewhat** ○ **Not Very Much** ○ **Not At All**

9) To what extent do you believe your **Life Area Map** helped you to identify these issues?

○ **Very Much** ○ **Somewhat** ○ **Not Very Much** ○ **Not At All**

10) Did you develop a written **Harm Reduction Goals**? ○ **Yes** ○ **No** ***(If 'NO,' go to Question 11)***

10.1) What is your **harm reduction goal**?
(Please Fill-in <u>ONE</u> Bubble Only.)

○ **To Remain Abstinent**
○ **To Reduce My Consumption**
○ **Other:** _____

10.2) To what extent do you believe you will be able to achieve this goal?

○ **Very Much** ○ **Somewhat** ○ **Not Very Much** ○ **Not At All**

11) How would you describe your current **Stage Of Change**? ***(Please Fill-in <u>ONE</u> bubble only.)***

○ **Precontemplative** ○ **Contemplative** ○ **Preparation** ○ **Action**

12) How confident are you that your problems (i.e. drinking and/or other drug use) are **now under control**?

○ **Very Confident** ○ **Somewhat Confident** ○ **Not Very Confident** ○ **Not Confident At All**

13) How were you received and supported regarding each of the following?

	Very Much	Somewhat	Not Very Much	Not At All
Were You Treated with respect?	○	○	○	○
Were You Treated honestly/openly?	○	○	○	○
Were You Treated courteously?	○	○	○	○
Was Your confidentiality Maintained?	○	○	○	○

59439

14) Overall, how satisfied were you with the services you received from the AFM?

○ **Very Satisfied** ○ **Somewhat Satisfied** ○ **Not Very Satisfied** ○ **Not Satisfied At All**

14.1) **Please expand** upon your answer. _____

_____

_____

15) Would you use the AFM in the future, if a similar problem arose?

○ **Definitely Would** ○ **Probably Would** ○ **Probably Would Not** ○ **Definitely Would Not**

16) Would you recommend the AFM to a friend or relative who had a problem similar to your own?

○ **Definitely Would** ○ **Probably Would** ○ **Probably Would Not** ○ **Definitely Would Not**

16.1) **Please expand** upon your answers (to Questions 15 & 16). _____

_____

_____

_____

17) **Additional Comments or Suggestions:** _____

_____

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

If you have any questions or comments that you would like to personally share, please feel free to contact the supervisor of the program you attended.

Please place the completed questionnaire in the envelope provided, seal it, and return it to your counsellor.

59439

'COMING TO TERMS' - STAFF EVALUATION

This form is to be completed by staff in AFM's Winnipeg Region's Community-Based Treatment Program. It is designed to assist with the evaluation of the ***Coming To Terms Program*** (CTT) which is just completing its pilot phase. Please take a few moments to complete this form.

1) What is your relationship with the Coming To Terms Program? **(Fill-In ALL That Apply.)**

- O Referred Clients To The CTT Program
- O Facilitated CTT Group(s)
- O No Involvement With Program
- O Other _____

2) Approximately how many clients did you refer to the CTT program? ***If 'None,' write '00'.'*** ☐☐

3) To what degree do you believe that the CTT program was successful in achieving each of the following objectives?

	TO WHAT EXTENT WAS EACH OBJECTIVE ACHIEVED?				
REGARDING CLIENTS NOT IN THE CTT PROGRAM:	**Very Much**	**Somewhat**	**Not Very Much**	**Not At All**	**Don't Know**
There will be fewer Precontemplative & Contemplative clients in groups with other clients. (i.e. Non-CTT Groups)	O	O	O	O	O
There will be fewer disruptions in other groups (i.e. those with no Precontemplative Or Contemplative clients).	O	O	O	O	O
Clients in other groups will be more cohesive.	O	O	O	O	O
Clients in other groups will be less antogonistic to one another.	O	O	O	O	O
Clients in groups will be more likely to complete treatment than they were when Precontemplative/Contemplative clients were in group with them.	O	O	O	O	O
Counsellors facilitating other groups will experience greater personal satisfaction following the advent of CTT.	O	O	O	O	O
REGARDING CLIENTS IN THE CTT PROGRAM					
These clients will participate in the group process.	O	O	O	O	O
These clients will complete their assignments.	O	O	O	O	O
These clients will maintain abstinence throughout the program.	O	O	O	O	O
These clients will attend at least one self help group meeting while attending this program.	O	O	O	O	O
These clients will develop achievable harm reduction goals.	O	O	O	O	O
These clients will be able to identify their substance abuse issues.	O	O	O	O	O
These clients will be more aware of the nature & severity of their chemical problems.	O	O	O	O	O
These clients will be more determined to address their alcohol or other drug problems.	O	O	O	O	O

4) Overall, how successful do you feel the Coming To Terms Program has been so far?

○ Very Successful ○ Somewhat Successful ○ Not Very Successful ○ Not Successful At All

4.1) Please explain your answer. What made the program either successful or unsuccessful, in your opinion?

5) If a colleague from another agency told you they were considering starting up a similar program, what advice would you give them? (eg. What should they consider doing or not doing? How should they get started? (etc.))

6) What do you see as the strengths of the Coming To Terms Program?

7) What do you see as the program's limitations?

8) Please feel free to provide any other comments or points you would like to make about the Coming To Terms Program.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!!

58425

APPENDIX TWO

A BRIEF REVIEW OF THE SEVEN STAGES OF CHANGE

DESCRIPTION OF THE STAGES OF CHANGE

LEVEL	INTERPRETATION
Precontemplative	Individual either has no awareness of a problem and therefore feels no need to change, or individual has some awareness but as yet has not felt any need to change.
Contemplative	Individual has enough information regarding his/her problem, and recognizes personal connection to the information. Individual is thinking about change, but may be a long way from being committed to change.
Preparation	The individual is actively preparing to change. Individual begins to consider the steps required to change his/her behaviour. This is an important precursor to the 'action' stage.
Action	Individual initiates changes prepared and planned for during the preparation stage. This may include eliminating some behaviours, modifying others and/or introducing new behaviours.
Maintenance	This is the stage in which the individual maintains changes made in the action stage, and builds on these changes. Successful change means change sustained over a long period of time.
Recycle	This stage occurs when, having made progress on previous stages, the client falls back to an earlier stage. This stage is positively viewed as an opportunity to learn from his/her mistakes.
Termination	*Termination* means exiting the spiral of change. The client no longer needs to attend to the task of maintaining change. This stage is the ultimate goal of the treatment process.
Source:	***Stages Of Change: Participant's Manual***, produced by the Addictions Foundation of Manitoba

APPENDIX THREE

SELECTED FREQUENCY TABLES FOR THE CLIENT SATISFACTION EVALUATION

Selected Frequencies Taken From Coming-To-Terms Client Satisfaction Evaluation

I learned healthier ways to cope or resolve my problems	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Not Very Much	0	.0%	2	16.7%	0	.0%	0	.0%	2	4.2%
Somewhat	1	50.0%	7	58.3%	9	45.0%	3	21.4%	20	41.7%
Very Much	1	50.0%	3	25.0%	11	55.0%	11	78.6%	26	54.2%
Total	2	100.0%	12	100.0%	20	100.0%	14	100.0%	48	100.0%

I feel better about myself (self-esteem)	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Not Very Much	0	.0%	4	33.3%	1	4.8%	1	7.1%	6	12.2%
Somewhat	2	100.0%	4	33.3%	15	71.4%	4	28.6%	25	51.0%
Very Much	0	.0%	4	33.3%	5	23.8%	9	64.3%	18	36.7%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

I developed a plan of action that I feel I can achieve	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Not Very Much	0	.0%	1	8.3%	2	9.5%	0	.0%	3	6.1%
Somewhat	1	50.0%	9	75.0%	11	52.4%	6	42.9%	27	55.1%
Very Much	1	50.0%	2	16.7%	8	38.1%	8	57.1%	19	38.8%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

Selected Frequencies Taken From Coming-To-Terms Client Satisfaction Evaluation

Do you feel you are now able to identify your personal Substance Abuse Issues?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Not Very Much	0	.0%	0	.0%	1	4.8%	0	.0%	1	2.0%
Somewhat	1	50.0%	6	50.0%	9	42.9%	5	35.7%	21	42.9%
Very Much	1	50.0%	6	50.0%	11	52.4%	9	64.3%	27	55.1%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

To what extent do you believe your Life Area Map helped you to identify these issues?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Not Very Much	0	.0%	0	.0%	2	9.5%	1	8.3%	3	6.5%
Somewhat	1	50.0%	7	63.6%	8	38.1%	6	50.0%	22	47.8%
Very Much	1	50.0%	4	36.4%	11	52.4%	5	41.7%	21	45.7%
Total	2	100.0%	11	100.0%	21	100.0%	12	100.0%	46	100.0%

To what extent do you believe you will be able to achieve this goal?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Somewhat	1	50.0%	6	66.7%	6	37.5%	2	15.4%	15	37.5%
Very Much	1	50.0%	3	33.3%	10	62.5%	11	84.6%	25	62.5%
Total	2	100.0%	9	100.0%	16	100.0%	13	100.0%	40	100.0%

Selected Frequencies Taken From Coming-To-Terms Client Satisfaction Evaluation

How confident are you that your problems are now under control?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Somewhat Confident	1	50.0%	8	66.7%	16	76.2%	6	42.9%	31	63.3%
Very Confident	1	50.0%	4	33.3%	5	23.8%	8	57.1%	18	36.7%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

EVALUATING THE SERVICES RESPONDENTS RECEIVED	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Were You Treated with respect?										
Somewhat	1	50.0%	1	8.3%	0	.0%	0	.0%	2	4.1%
Very Much	1	50.0%	11	91.7%	21	100.0%	14	100.0%	47	95.9%
Were You Treated honestly/openly?										
Somewhat	0	.0%	2	16.7%	1	4.8%	0	.0%	3	6.1%
Very Much	2	100.0%	10	83.3%	20	95.2%	14	100.0%	46	93.9%
Were You Treated courteously?										
Somewhat	0	.0%	1	8.3%	1	4.8%	0	.0%	2	4.1%
Very Much	2	100.0%	11	91.7%	20	95.2%	14	100.0%	47	95.9%
Was Your confidentiality Maintained?										
Somewhat	1	50.0%	1	8.3%	3	14.3%	0	.0%	5	10.4%
Very Much	1	50.0%	11	91.7%	18	85.7%	13	100.0%	43	89.6%

Selected Frequencies Taken From Coming-To-Terms Client Satisfaction Evaluation

Overall, how satisfied were you with the services you received from the AFM?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Somewhat Satisfied	0	.0%	5	41.7%	7	33.3%	2	14.3%	14	28.6%
Very Satisfied	2	100.0%	7	58.3%	14	66.7%	12	85.7%	35	71.4%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

Would you use the AFM in the future, if a similar problem arose?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Probably Would Not	0	.0%	0	.0%	1	4.8%	0	.0%	1	2.0%
Probably Would	1	50.0%	6	50.0%	9	42.9%	6	42.9%	22	44.9%
Definitely Would	1	50.0%	6	50.0%	11	52.4%	8	57.1%	26	53.1%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%

Would you recommend the AFM to a friend or relative who had a problem similar to your own?	How would you describe your current Stage Of Change?								Total	
	Precontemplative		Contemplative		Preparation		Action		Count	Col %
	Count	Col %	Count	Col %	Count	Col %	Count	Col %		
Probably Would	1	50.0%	4	33.3%	9	42.9%	4	28.6%	18	36.7%
Definitely Would	1	50.0%	8	66.7%	12	57.1%	10	71.4%	31	63.3%
Total	2	100.0%	12	100.0%	21	100.0%	14	100.0%	49	100.0%